

The background of the slide is a blurred photograph of a medical professional in a white coat, possibly a nurse or doctor, with their hands near a patient. A large, semi-transparent green cross is centered over the image. Various medical icons are overlaid in a light green color, including a syringe, a pill, a virus particle, a stethoscope, and a group of three people. A network of thin green lines connects some of these icons. The right side of the slide features a dark grey diagonal band that serves as a background for the text.

# **South Dakota Department of Human Services**

## **Medicaid Nursing Home Rate Methodology Review**

May 28, 2021



**MYERS AND  
STAUFFER<sub>LLC</sub>**  
CERTIFIED PUBLIC ACCOUNTANTS



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# Executive Summary

The South Dakota Medicaid Nursing Facility Reimbursement Review Study was initiated in 2019 to fulfill the requirements that a comprehensive rate modeling analysis be completed at least every five years. This study also addressed concerns about the federal transition to the Patient Driven Payment Model (PDPM) and the potential impact that change might have on the Medicaid nursing facility reimbursement system.

The core of the reimbursement system analysis was the development of an Excel-based rate model. This model mimicked the current rate methodology and also included options to adjust multiple rate parameters within the current methodology such as the cost ceiling calculations. The model also included options for incorporating new reimbursement methodology parameters such as moving to a price-based rate calculation for specific rate components instead of a cost-based rate calculation. A value based purchasing worksheet was included in the model to investigate different pay for performance options. Rate parameter settings and analysis of the projected rates those settings would produce was provided through a Parameters and Analysis worksheet within the model. This enabled users to review the estimated impact of countless combinations of rate setting parameters.

To gain input from stakeholders, a workgroup was organized including representatives from the nursing facility industry. Each of the South Dakota nursing facility trade associations were represented in this workgroup as well as individuals from other state agencies.

A critical issue facing acuity-based Medicaid nursing facility reimbursement systems is the Centers for Medicare and Medicaid (CMS) transition from the Resource Utilization Groups (RUG) classification system to the Patient Driven Payment Model (PDPM). Since South Dakota relies on the RUG system now to adjust payments to reflect the acuity of each Medicaid resident, any change to the RUG system could potentially impact the State's ability to continue its current payment methodology. The potential impact of this CMS transition was investigated and options were developed for addressing this change. At present, CMS continues to support the RUG system and no change is required. However the State should anticipate moving to the PDPM system within the next few years.

The Analysis and Findings section of this report includes an evaluation of the current methodology, identification of its strengths and weaknesses, information gathered from provider surveys, a review of multiple reimbursement parameters, analysis of cost center ceilings, value based purchasing modeling, analysis of extraordinary care, and cost reporting discussions.

Several recommendations were made as a result of this review. These include adopting an industry-specific inflation index, eliminating the dual ceiling methodology, incorporating value based purchasing, creating property incentives, and automating extraordinary care payments. A table summarizing these recommendations begins on page 52.



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Several appendices are also included to provide additional background on certain subjects. These include Senate Bill 147, the stakeholder workgroup, the provider survey, the case mix rate model, FRV models, BIMS/CPS, and the Medicaid cost report.



# Project Overview

The South Dakota Medicaid Nursing Facility Reimbursement Review Study was initiated in 2019 to fulfill the requirements outlined in Senate Bill 147 (SB 147). SB 147 requires that a comprehensive rate modeling analysis be completed at least every five years for each category of community-based health and human services providers. The bill identified ten different types of community-based providers including nursing facilities. The Department established a five-year rotating schedule to conduct reimbursement system reviews for each provider type.

Nursing facilities were originally included in the group of providers to be reviewed during year four of the Department's rotating schedule. However, the Department moved nursing facilities up in the scheduled review order at the request of the Legislative Joint Appropriations Committee. The Committee had received information indicating that the nursing home program was underfunded and the gap between allowable costs and the Medicaid rates was expanding.

Another issue that contributed to the Department's decision to move up the nursing facility rate review was concern about the impact of changes in Medicare nursing facility reimbursement policies. Those changes included the implementation of the Patient Driven Payment Model (PDPM) by the Centers for Medicare and Medicaid Services (CMS), and related adjustments to the data that is collected on nursing facility resident assessments. PDPM is an acuity-based reimbursement system and it replaced the Resource Utilization Groups (RUGs) system that CMS had used for more than 30 years. Like many states, the South Dakota nursing facility reimbursement system includes an acuity-based adjustment component that utilizes the RUGs system. Addressing the uncertainty over the ongoing viability of a RUG-based system became a primary concern for the Department when the federal reimbursement changes were announced. Analyzing and addressing the impact of the implementation of PDPM and related changes is a primary objective of this review.

The broader objective of the reimbursement review study is to evaluate the current methodology, consider relevant variables and make recommendations for changes to the nursing home reimbursement methodology. Through the review process every aspect of the South Dakota nursing facility reimbursement system was examined. Throughout the process specific consideration was given to Medicaid upper payment limit calculations, rate setting and reimbursement model development, financial analysis/modeling including what/if scenarios, analytics and forecasting, performance based contracting, and infographic creation.

## Procurement and Contracting

On March 29, 2019, the South Dakota Department of Human Services published Request for Proposal (RFP) #1639. The purpose of this proposal was to establish a contract with a consultant qualified in the evaluation and design of rate methodologies as related to nursing home reimbursement. Five bidders



submitted proposals through the RFP process and Myers and Stauffer LC was selected to complete the nursing facility rate review study in June of 2019.

Myers and Stauffer LC is a certified public accounting firm specializing in government health care. The firm has nearly 40 years of nursing facility (NF) rate setting, auditing, and consulting experience spanning across more than 35 states. Myers and Stauffer is a national leader in case mix reimbursement services and MDS review, with a history of development work and partnership with the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies that dates back to the 1980s. The firm also has a long-standing working relationship with South Dakota that involves various projects including completing the State's annual nursing facility upper payment limit demonstration. Myers and Stauffer maintains dialogues with CMS executives, state Medicaid officials and industry leaders across the nation in order to provide clients with guidance and assistance on all aspects of Medicaid reimbursement. The Myers and Stauffer team includes former CMS and state government employees, policy experts, informaticists, pharmacists, medical doctors, certified public accountants (CPAs), registered nurses (RNs), certified coders, former nursing home employees, former hospital accountants, former Medicare intermediary auditors, former state Medicaid Surveillance and Utilization Review coordinators, and certified fraud examiners (CFEs).

### Overview of Rate Review Approach

Myers and Stauffer prepared a four-phase work plan for the rate review project. Phase I – Initial Model Development, included a project kickoff meeting, review and adjustment of the work plan, review of the current reimbursement methodology, gathering of cost report and case mix data, development of a case-mix reimbursement model, and development of a case-mix decision matrix. Phase II – Methodology Development, included presenting the reimbursement model to stakeholders, conducting meetings with the stakeholder workgroup to discuss and model different rate setting parameters, and preparation of a draft rate review report. Phase III – Methodology Implementation included finalizing the rate review report, developing an implementation plan, and assistance with applicable state plan amendments and other policy modifications. Phase IV – Long Term Activities, includes providing ongoing support and evaluation of the reimbursement system.



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# Reimbursement Model

A key deliverable from the rate review project is the case-mix reimbursement model. The model was built in Excel to provide a way for calculating updated rates under the current reimbursement parameters. Flexibility was also incorporated to allow for adjustments to the current parameters as well as modeling of new rate options such as value-based payment incentives.

## Parameters and Analysis

The main page of the model is the Parameters and Analysis worksheet. This worksheet identifies the reimbursement parameters for each cost center and pulls together summary statistics that provide a quantitative analysis of the rates produced under the parameter settings. The Parameters and Analysis worksheet includes sections for general settings, as well as sections for each of the following cost centers; Direct Care, General Administrative, Combined Non-Direct Care, and Capital. There is also an Overall Analysis section to analyze total rate calculations and the overall fiscal impact to the Medicaid program.



South Dakota Case Mix Rate Model									
Date Prepared: 2/26/2020 Version: 1.9		<b>DRAFT - Subject To Change - Not for General Distribution</b> This model was developed by Myers and Stauffer LLC for the South Dakota Department of Human Services. It is a working model and subject to change. It is intended for use by the Department and the workgroup they have assembled.							
Parameters and Analysis									
General									
Cost Report Data for Fiscal Years Ending In: 2018		Rate Analysis Groupings:							
Inflation Options: Index: CPI Through Date: 12/31/20		HB/FS: Hospital Based (shared costs with hospital) vs. Free Standing Facilities U/R: Urban (within OMB defined CBSA) vs. Rural S/L: Small vs. Large Facilities Small Facilities are < or = 60 beds							
		Analysis Group:							
		Count:							
		All HB FS U R S L AC NFs 638 NFs							
		106 19 87 28 78 67 39 9 1							
Direct Care									
Type of Rate: Cost - Ceilings		Occupancy Rule: Y		Rate Analysis		All HB FS U R S L AC NFs 638 NFs			
				Wtd. Avg. Rate:		\$ 98.94 \$109.50 \$ 96.87 \$103.72 \$ 97.10 \$ 92.49 \$104.54 \$ 98.97 \$ 86.80			
				Maximum Rate:		\$165.57 \$165.57 \$164.94 \$151.10 \$165.57 \$165.57 \$151.10 \$165.57 \$ 86.80			
				Minimum Rate:		\$ 54.32 \$ 66.58 \$ 54.32 \$ 70.78 \$ 54.32 \$ 54.32 \$ 70.78 \$ 54.32 \$ 86.80			
				Average Cost Coverage:		98.06% 95.00% 99.00% 98.00% 98.00% 99.00% 97.00% 100.00% 100.00%			
				Facilities Impacted by Max Limit		14 5 9 4 10 5 9 0 0			
				Facilities Impacted by Min Limit		24 7 17 10 14 8 16 0 0			
CMI Data Options:		Exclude Mdr							
Overall CMI Calculation									
Medicaid CMI Source									
Ceiling/Limit/Price Calculations:				Special Limits/Ceilings		Maximum Rate @ CMI 1.0:			
Median		\$ 86.51		AC NFs: 100% of costs.		\$106.41			
Max. Ceiling/Limit/Price		125% \$ 108.14		638 NFs: 100% of costs.					
Min. Ceiling		115% \$ 99.49							
Exclude CMI < 1.0:		Y							
General Administrative									
Type of Rate: Cost - Ceilings		Occupancy Rule: Y		Rate Analysis		All HB FS U R S L AC NFs 638 NFs			
				Wtd. Avg. Rate:		\$ 19.57 \$ 18.69 \$ 19.74 \$ 19.93 \$ 19.43 \$ 19.38 \$ 19.73 \$ 18.35 \$ 32.88			
				Maximum Rate:		\$ 32.88 \$ 20.33 \$ 32.88 \$ 20.33 \$ 32.88 \$ 32.88 \$ 20.33 \$ 19.58 \$ 32.88			
				Minimum Rate:		\$ 10.85 \$ 10.85 \$ 13.66 \$ 13.78 \$ 10.85 \$ 10.85 \$ 13.76 \$ 10.85 \$ 32.88			
				Average Cost Coverage:		73.48% 78.00% 73.00% 65.00% 77.00% 78.00% 69.00% 75.00% 100.00%			
				Facilities Impacted by Max Limit		77 12 65 23 54 46 31 7 0			
				Facilities Impacted by Min Limit		80 12 68 24 56 47 33 7 0			
Other Rate Options:		Include with Non-Direct N							
Ceiling/Limit/Price Calculations				Special Limits/Ceilings		Maximum Rate:			
Median		\$ 18.65		AC NFs: 105% of median.		\$ 20.33			
Max. Ceiling/Limit/Price		110% \$ 20.52		638 NFs: 100% of costs.					
Min. Ceiling		105% \$ 19.58							
Exclude CMI < 1.0:		Y							
Exclude Chains		Y							
Combined Non-Direct Care									
Type of Rate: Cost - Ceilings		Occupancy Rule: Y		Rate Analysis		All HB FS U R S L AC NFs 638 NFs			
				Wtd. Avg. Rate:		\$ 68.00 \$ 72.62 \$ 67.09 \$ 66.45 \$ 68.60 \$ 67.32 \$ 68.59 \$ 69.93 \$ 76.45			
				Maximum Rate:		\$ 77.25 \$ 77.25 \$ 77.25 \$ 77.25 \$ 77.25 \$ 77.25 \$ 77.25 \$ 77.25 \$ 76.45			
				Minimum Rate:		\$ 41.41 \$ 55.64 \$ 41.41 \$ 50.91 \$ 41.41 \$ 42.35 \$ 41.41 \$ 56.80 \$ 76.45			
				Average Cost Coverage:		96.41% 91.00% 97.00% 99.00% 96.00% 97.00% 96.00% 95.00% 99.00%			
				Facilities Impacted by Max Limit		24 10 14 2 22 13 11 4 0			
				Facilities Impacted by Min Limit		37 14 23 7 30 24 13 4 1			
Ceiling/Limit/Price Calculations				Special Limits/Ceilings		Maximum Rate:			
Median		\$ 70.87		AC NFs: 105% of median.		\$ 77.25			
Max. Ceiling/Limit/Price		110% \$ 77.96		638 NFs: 100% of costs.					
Min. Ceiling		105% \$ 74.41							
Exclude CMI < 1.0:		Y							
Capital									
Type of Rate: Current				Rate Analysis		All HB FS U R S L AC NFs 638 NFs			
				Wtd. Avg. Rate:		\$ 10.88 \$ 8.31 \$ 11.38 \$ 12.26 \$ 10.34 \$ 8.52 \$ 12.92 \$ 8.98 \$ 3.91			
				Maximum Rate:		\$ 17.62 \$ 17.62 \$ 17.62 \$ 17.62 \$ 17.62 \$ 17.62 \$ 17.62 \$ 17.62 \$ 3.91			
				Minimum Rate:		\$ 0.54 \$ 1.29 \$ 0.54 \$ 0.93 \$ 0.54 \$ 0.54 \$ 3.50 \$ 1.29 \$ 3.91			
				Average Cost Coverage:		93.56% 95.00% 93.00% 92.00% 94.00% 97.00% 90.00% 90.00% 100.00%			
				Facilities Impacted by Limit		19 3 16 7 12 7 12 2 0			
Ceiling/Limit/Price Calculations				Special Limits/Ceilings		Maximum Rate:			
Median		\$ 11.05		AC NFs: 105% of median.		\$ 17.62			
Max. Ceiling/Limit		160% \$ 17.62		638 NFs: 100% of costs.					
Min. Ceiling		NA							
Overall Analysis									
Estimated Fiscal Impact				Rate Analysis		All HB FS U R S L AC NFs 638 NFs			
Wtd. Avg. Rate		\$ 170.24		Wtd. Avg. Rate:		\$170.24 \$184.25 \$167.49 \$171.41 \$169.79 \$166.05 \$173.87 \$188.63 \$200.04			
Medicaid Days		1,046,134		Maximum Rate:		\$225.37 \$225.37 \$210.99 \$210.99 \$225.37 \$225.37 \$201.81 \$225.37 \$200.04			
Estimated Cost		\$ 178,095,210.65		Minimum Rate:		\$127.27 \$138.48 \$127.27 \$127.27 \$129.42 \$127.27 \$138.20 \$137.43 \$200.04			
Estimated VBP Payments		\$ 1,887,863.00		Average Cost Coverage:		84.98% 83.00% 85.00% 84.00% 85.00% 88.00% 82.00% 92.00% 102.00%			
Total Wtd. Avg. Rate		\$ 172.05		Facilities Impacted by Increase Limit:		94 15 79 26 68 56 38 3 0			
Impose Increase Limit:		Reg NF Increase Limit %:		AC NF Increase Limit %:		638 NF Increase Limit %:			
Y		8%		10%		10%			

Figure 1: Rate Model Parameters and Analysis Worksheet



The General settings section was set up to control some basic inputs that apply to all cost centers and provide some overall statistics. The cost report data used in the model is identified here. Cost reports for fiscal years ending in 2018 were used as the base data for the model. Inflation settings are also included in this section. Users had the ability to select the type of index to use for inflation calculations with choices of the consumer price index (CPI), or the Global Insight Skilled Nursing Facility Market Basket Index. The endpoint for inflation calculations was identified in this section, and it was predetermined that all inflation would be applied through December 31, 2020 so that rate calculations would be applicable to state fiscal year 2021. This section also includes facility groupings used for analyzing the impact of the rates on different types of providers. These groups included hospital based (HB) and free standing (FS) facilities, urban (U) and rural (R) facilities, and large (L) and small (S) facilities. The user was given the ability to define small facilities by inputting a bed count threshold. For the modeling results presented in this report and considered throughout most of the rate review discussions 60 or fewer beds was used as the definition of a small facility.

For informational purposes a table was included showing the total number of facilities included in the modeling and the breakdown of facilities by the different types of facilities. A total of 106 facilities were included in the modeling, with 19 being hospital-based, and 87 being free standing facilities. Urban facilities account for 28 of the providers included in the model and 78 facilities were considered rural. The CMS Core-based Statistical Areas (CBSA) were used to determine whether a facility was considered rural or urban. Using the 60-bed threshold for small facilities put 67 facilities in that category, with 39 providers being classified as large facilities. Additional categories were added to the model through the review process to analyze and review information for access critical facilities (AC NF), and Indian Health Services Tribally-Operated 638 Program Providers (638 NF). The AC NFs designation was created by the Department several years ago and assigned to facilities based on criteria intended to identify facilities in areas that lack multiple options for long-term care. There are currently nine facilities with this designation. The 638 NFs are facilities operated by tribal organizations. One facility was included as a 638 NF in the rate review process. A second 638 NF has enrolled in the Medicaid program but had not submitted financial data before the analysis was completed. Both AC NF and 638 NF providers are subject to alternative reimbursement rules. These alternative rules will be explained in detail within the applicable sections of the reimbursement system analysis.

Within the Parameters and Analysis tab of the rate model are individual sections for each cost center. These sections define cost center specific rate parameters. For each cost center users were given the option to select the Type of Rate calculation to be modeled. There were options for Cost with Ceilings (current methodology using a two-tier ceiling limit), Cost with Limit (using one limit rather than two), and Price (using a fixed rate for all providers). For each cost center an option was also included to apply the current occupancy rule or not. Finally within each cost center users were given the ability to adjust the percentage applied to the median to determine the cost center ceilings/limits.



There were a few parameters and rate setting options that were specific to the Direct Care cost center. A couple of these related to the CMI data used for acuity adjustments. It was predetermined to exclude Medicare data from the overall CMI calculation. It was also predetermined that 2018 would be the source year for Medicaid CMI data. In addition to the general parameter adjustments common to all cost centers (type of rate, occupancy rule, and ceiling percentages) user were given the option to decide whether the array used to determine the median cost for ceiling calculations would include providers with an average CMI less than 1.0.

The General Administrative cost center also included some parameters that users could define. This included the option to combine this cost center with other non-direct costs. It also included the option to exclude providers with a CMI less than 1.0 from the array used to determine the median cost for ceiling calculations. In the same respect, an option was included to allow users to exclude providers affiliated with chains from the ceiling calculations.

The Non-Direct Care cost center only included one cost center specific rate parameter. That was whether or not to include facilities with a CMI less than 1.0 from the median calculation used to establish the ceiling(s).

The Capital cost center included just a few different options that could be used to adjust the type of rate in addition to the general adjustments that were common to each cost center. These included the option to just use the current limit, and an option to use a fair rental value system.

There were a few options included in the Overall Analysis sections that could be applied to the final rate calculations. This included the ability to impose an overall rate increase limit. The ability to adjust that limit was also included for regular nursing facilities, AC NFs, and 638 NFs.

In addition to all of the options to adjust parameters for each cost center, the Parameters and Analysis tab included statistics for each cost center to help users analyze the impact of any adjustment made to the parameters. The same statistics were calculated for each cost center. They included a weighted average rate, a maximum rate, a minimum rate, the average cost coverage, and the number of facilities that were impacted by the ceiling(s). Within each cost center these statistics were provided for all facilities as well as the different groupings of facilities discussed earlier. Those groupings included hospital based and free standing facilities, urban and rural facilities, small and large facilities, access critical facilities, and IHS 638 program facilities. These same statistics and groupings were also used for the overall rates in the Overall Analysis section.

### Value Based Purchasing

The second tab included in the model was the Value Based Purchasing tab. This tab included options for users to set parameter options for different components of a value based payment system. These options did not involve any existing rate parameters. The options that were included utilized the CMS



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Five-Star ratings data and some of the data that stands behind those ratings. This included the health inspections ratings, the overall five-star ratings, the staffing ratings, the quality measures ratings, and the quality measures scoring for long-stay measures. This worksheet also included statistics showing the estimated fiscal impact of the parameters set by the user, the percent of total estimated Medicaid expenditures represented by the modeled VBP program, and the number of facilities that would qualify for an incentive under the model parameters. An average incentive per diem for qualifying providers, as well as the average total estimated annual payment was also included. Similarly the maximum per diem incentive and maximum total payment were also identified.



Value Based Purchasing Worksheet

South Dakota Case Mix Rate Model

Date Prepared: 2/26/2020

Version: 1.9

**DRAFT - Subject To Change - Not for General Distribution**

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Value Based Purchasing

VBP Parameters

Health Inspection			Overall 5-Star Rating			Staffing 5-Star Rating			QM 5-Star Rating			QM Scoring			
Rating	Facilities	VBP %	Rating	Facilities	Rate	Rating	Facilities	Rate	Rating	Facilities	Rate	Tier	Min Score	Facilities	Rate
5	9	100%	5	21	0.00	5	21	6.00	5	26	0.00	1	680	9	6.00
4	25	100%	4	28	0.00	4	37	3.00	4	25	0.00	2	620	22	3.00
3	20	100%	3	19	0.00	3	23	1.00	3	35	0.00	3	560	23	1.00
2	22	0%	2	21	0.00	2	4	0.00	2	10	0.00	4	500	25	0.00
1	22	0%	1	9	0.00	1	13	0.00	1	2	0.00	5	320	23	0.00
0	8	0%	0	8	0.00	0	8	0.00	0	8	0.00	0	0	4	0.00
106			106			106			106			106			
												Median is 560, 75th Percentile is 620			
Estimated Fiscal Impact			\$ 1,887,863.00						PPD			Total VBP Payment			
Percent of Total Expenditures			1.05%			Average Incentive (Qualifying NFs)			\$ 4.52			\$ 36,305			
Facilities Qualifying for Incentive			52			Maximum Incentives			\$ 12.00			\$ 112,116			

Figure 2: Rate Model Value Base Purchasing Worksheet



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### Cost Center Assignment

Another tab in the model allowed users to designate which cost center specific cost report line items would be included in and to also determine if those line items would be subject to inflation factors or not. The cost center options included Direct Care – Non-Therapy, Direct Care – Therapy, Health and Subsistence, General Administrative, Other Operating, Plant/Operational, Capital, Other, and a category for line items not assigned to any cost center. Inflation options only included the ability to determine whether inflation was applied to each specific cost report line item or not. This worksheet allowed users to realign how costs are grouped within the reimbursement system.



## Cost Center Assignment

Center		Cost Center Title	Center	Inflate?	Description	Center	Inflate?	Description		
0		Not Assigned (Totals etc.)	2	Y	B-9 Other Dietary Salaries Salaries	4	Y	D-1 Worker'S Comp Other		
1A		Direct Care - Non-Therapy	2	Y	B-10 Dietary Consultant Fees Other	4	Y	D-2 Unemp. Ins Other		
1B		Direct Care - Therapy	2	Y	B-11 Dietary Supplies Other	4	Y	D-3 Real Estate Taxes Other		
2		Health and Subsistence	2	Y	B-12 Food Purchases Other	4	Y	D-4 Patient Care/Med Related Travel Other		
3		General Administrative	2	Y	B-13 Laundry Supervisor Salaries	0	Y	D-5 Total Other Operating Other		
4		Other Operating	2	Y	B-14 Other Laundry Salaries Salaries	0	Y	D-5 Total Other Operating Adj Total		
5		Plant/Operational	2	Y	B-15 Laundry Supplies Other	5	Y	E-1 Maint Supervisor Salaries		
6		Capital	2	Y	B-16 Nursing Aide Training Costs Other	5	Y	E-2 Other Maint Salaries Salaries		
7		Other	2	Y	B-17 Nursing Aide Testing Costs Other	5	Y	E-3 Maint Supplies & Repairs Other		
			2	Y	B-18 Inservice Training Director Salaries	5	Y	E-4 Housekeeping Salaries Salaries		
			2	Y	B-19 Inservice Training Personnel Salaries	5	Y	E-5 Other Housekeeping Salaries Salaries		
			2	Y	B-20 Inservice Training Contracted Other	5	Y	E-6 Housekeeping Supplies Other		
			2	Y	B-21 Inservice Training Other Other	5	Y	E-7 Utilities Other		
			2	Y	B-22 FICA Other	5	Y	E-8 Interest- Working Capital Other		
			2	Y	B-23 Employee Fringe Benefits Other	5	Y	E-9 Vehicle Supplies & Repairs Other		
			2	Y	B-24 Other Emp F/B Vaccin, Physicals Other	5	Y	E-10 Vehicle Insurance Other		
			2	Y	B-25 Other Health And Subsistence Salaries	5	Y	E-11 Vehicle Deprec. Other		
			2	Y	B-25 Other Health And Subsistence Other	5	Y	E-12 Vehicle Leases Other		
			0	Y	B-26 Total Health And Subsistence Salaries	5	Y	E-13 FICA Other		
			0	Y	B-26 Total Health And Subsistence Other	5	Y	E-14 Emp Fringe Benefits Other		
			0	Y	B-26 Total Health And Subsistence Adj Total	5	Y	E-15 Other Plant/Oper. Other		
			3	Y	C-1 Administrator Salaries	0	Y	E-16 Total Plant/Oper. Salaries		
			3	Y	C-2 Asst Administrator Salaries	0	Y	E-16 Total Plant/Oper. Other		
			3	Y	C-3 Office Salaries Salaries	0	Y	E-16 Total Plant/Oper. Adj Total		
			3	Y	C-4 Non-Owner'S Directors Fees Other	6	N	F-1 Building Insurance Other		
			3	Y	C-5 Office Supplies Other	6	N	F-2 Building Deprec. Other		
			3	Y	C-6 Postage Expense Other	6	N	F-3 Furniture & Equip Deprec Other		
			3	Y	C-7 Telephone Expense Other	6	N	F-4 Amort. (Org/Pre-Oper.) Other		
			3	Y	C-8 Advertising Expense Other	6	N	F-5 Interest-Mortgage Other		
			3	Y	C-9 Central Office Expense Other	6	N	F-6 Rent- Facility & Grounds Other		
			3	Y	C-10 Legal & Accounting Expense Other	6	N	F-7 Rent- Equip. Other		
			3	Y	C-11 Professional Liability Expense Other	0	N	F-8 Total Capital Expenditures Other		
			3	Y	C-12 Dues, Fees, Licenses, & Subscript Other	0	N	F-8 Total Capital Expenditures Adj Total		
			3	Y	C-13 Admin. Travel Other	0	Y	G-1 Total Direct Care (Sec. A) Salaries		
			3	Y	C-14 FICA Other	0	Y	G-1 Total Direct Care (Sec. A) Other		
			3	Y	C-15 Emp. Fringe Benefits Other	0	Y	G-1 Total Direct Care (Sec. A) Adj Total		
			3	Y	C-16 Other Admin. Other	0	Y	G-2 Total Non-Direct Care (Sec. B-E) Salaries		
			0	Y	C-17 Total Admin. Salaries	0	Y	G-2 Total Non-Direct Care (Sec. B-E) Other		
			0	Y	C-17 Total Admin. Other	0	Y	G-2 Total Non-Direct Care (Sec. B-E) Adj Total		
			0	Y	C-17 Total Admin. Adj Total	0	Y	G-3 Total Capital Expenditures (Sec F.) Other		
						0	Y	G-3 Total Capital Expenditures (Sec F.) Adj Total		
						0	Y	G-4 Total Reported Costs Salaries		
						0	Y	G-4 Total Reported Costs Other		
						0	Y	G-4 Total Reported Costs Adj Total		
						0	Y	H-1 Return On Net Equity Other		
						0	Y	H-2 Total Recognized Costs Salaries		
						0	Y	H-2 Total Recognized Costs Other		
						0	Y	H-2 Total Recognized Costs Adj Total		
Inflate										

Figure 3: Rate Model Cost Center Assignment



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### Rate List

To provide users with facility-specific rate information a worksheet was included to produce a list of rates and their component parts for each facility. This worksheet used a random number assigned to each facility to keep the rate listing anonymous. However, each facility was described by its characteristics (free-standing/hospital based, rural/urban, and small/large). CMS Five Star ratings were also included so the user could see the health inspection rating, the staffing rating, the QM rating, and the overall rating. The base rate components were also listed for each facility including the per diem amounts for Direct Care per diem, General Administrative, Non-Direct Care, Capital, and Rate Increase Adjustments, as well as the Calculated Medicaid Rate. Finally, for the VBP modeling, the modeled VBP add-on amount was shown along with the Total Modeled Rate. This worksheet allowed the users to evaluate rate changes triggered by changes in the rate setting parameters.



## Rate List Worksheet

Random Number	Facility Characteristics			CMS 5-Star Ratings				Base Rate Components and Total Rate						VBP Component	
	FS/HB	R/U	S/L	Health Inspection	Staffing	Quality Measures	Overall	Direct Care	General Admin	Non-Direct Care	Capital	Rate Inc Limit Adjustment	Calculated Medicaid Rate	VBP Add-on	Total Modeled Rate
101	FS	R	S	2	3	4	2	\$ 86.91	\$ 20.33	\$ 67.49	\$ 7.94	\$ 43.31	\$ 139.36	\$ -	\$ 139.36
102	FS	R	L	2	4	4	2	\$ 109.22	\$ 20.33	\$ 55.17	\$ 11.72	\$ 52.39	\$ 144.05	\$ -	\$ 144.05
103	HB	R	S	3	1	3	3	\$ 117.32	\$ 18.49	\$ 77.25	\$ 1.29	\$ 13.16	\$ 201.19	\$ -	\$ 201.19
104	FS	R	S	1	3	3	1	\$ 92.34	\$ 20.33	\$ 77.25	\$ 5.93	\$ 37.80	\$ 158.05	\$ -	\$ 158.05
105	FS	U	L	1	4	2	1	\$ 132.26	\$ 20.33	\$ 55.11	\$ 13.13	\$ 63.96	\$ 156.87	\$ -	\$ 156.87
106	FS	R	S	4	4	3	4	\$ 91.03	\$ 20.33	\$ 46.18	\$ 10.91	\$ 15.85	\$ 152.60	\$ 4.00	\$ 156.60
107	FS	R	S	4	3	3	4	\$ 94.77	\$ 20.33	\$ 58.57	\$ 11.68	\$ 55.93	\$ 129.42	\$ 1.00	\$ 130.42
108	FS	U	L	2	3	4	2	\$ 92.41	\$ 20.33	\$ 74.99	\$ 16.10	\$ 20.12	\$ 183.71	\$ -	\$ 183.71
109	FS	R	S	3	4	5	3	\$ 88.61	\$ 20.33	\$ 44.72	\$ 10.70	\$ 23.93	\$ 140.43	\$ 6.00	\$ 146.43
110	FS	R	L	1	4	5	1	\$ 105.96	\$ 20.33	\$ 74.34	\$ 17.62	\$ 35.99	\$ 182.26	\$ -	\$ 182.26
111	FS	R	L	4	5	3	4	\$ 110.67	\$ 20.33	\$ 77.25	\$ 17.62	\$ 34.08	\$ 191.79	\$ 6.00	\$ 197.79
112	FS	U	L	4	4	5	4	\$ 93.71	\$ 13.78	\$ 67.11	\$ 15.34	\$ 24.92	\$ 165.02	\$ 3.00	\$ 168.02
113	FS	R	S	0	0	0	0	\$ 80.31	\$ 20.33	\$ 75.31	\$ 3.77	\$ 11.51	\$ 168.21	\$ -	\$ 168.21
114	FS	R	L	4	5	3	4	\$ 113.01	\$ 13.76	\$ 77.25	\$ 17.62	\$ 33.35	\$ 188.29	\$ 6.00	\$ 194.29
115	FS	R	S	4	5	3	4	\$ 92.35	\$ 15.06	\$ 42.35	\$ 5.87	\$ 2.97	\$ 152.66	\$ 6.00	\$ 158.66
116	FS	U	L	0	0	0	0	\$ 89.05	\$ 20.33	\$ 50.91	\$ 17.62	\$ 19.34	\$ 158.57	\$ -	\$ 158.57
117	FS	R	S	2	4	3	2	\$ 107.58	\$ 20.33	\$ 55.18	\$ 11.35	\$ 54.83	\$ 139.61	\$ -	\$ 139.61
118	HB	R	L	1	4	2	1	\$ 119.18	\$ 20.33	\$ 77.25	\$ 3.50	\$ 29.14	\$ 191.12	\$ -	\$ 191.12
119	FS	R	L	2	5	4	2	\$ 103.22	\$ 20.33	\$ 77.25	\$ 17.62	\$ 16.61	\$ 201.81	\$ -	\$ 201.81
120	FS	U	L	1	4	3	1	\$ 70.78	\$ 20.33	\$ 63.61	\$ 17.62	\$ -	\$ 172.34	\$ -	\$ 172.34
121	FS	R	S	3	1	5	3	\$ 92.58	\$ 19.58	\$ 72.32	\$ 10.22	\$ -	\$ 194.70	\$ 3.00	\$ 197.70
122	FS	R	S	4	4	4	4	\$ 89.81	\$ 15.35	\$ 63.33	\$ 7.28	\$ 30.67	\$ 145.10	\$ 6.00	\$ 151.10
123	FS	R	S	3	2	3	3	\$ 104.83	\$ 20.33	\$ 67.95	\$ 8.59	\$ 43.26	\$ 158.44	\$ 3.00	\$ 161.44
124	FS	U	L	2	4	4	2	\$ 132.23	\$ 20.33	\$ 74.67	\$ 16.23	\$ 68.75	\$ 174.71	\$ -	\$ 174.71
125	HB	R	S	2	4	3	2	\$ 104.66	\$ 19.58	\$ 77.25	\$ 17.62	\$ -	\$ 219.11	\$ -	\$ 219.11
126	FS	R	S	1	4	2	1	\$ 93.69	\$ 18.17	\$ 77.25	\$ 14.63	\$ 14.47	\$ 189.27	\$ -	\$ 189.27
127	HB	R	S	4	4	4	4	\$ 73.71	\$ 20.33	\$ 57.16	\$ 11.72	\$ 18.26	\$ 144.66	\$ 3.00	\$ 147.66
128	FS	U	S	3	4	5	3	\$ 78.00	\$ 20.33	\$ 65.69	\$ 17.62	\$ 34.93	\$ 146.71	\$ 4.00	\$ 150.71
129	FS	R	S	2	3	5	2	\$ 54.32	\$ 19.58	\$ 56.80	\$ 6.73	\$ -	\$ 137.43	\$ -	\$ 137.43
130	FS	R	S	3	4	4	3	\$ 67.22	\$ 17.03	\$ 47.95	\$ 9.14	\$ 11.10	\$ 130.24	\$ 4.00	\$ 134.24
131	FS	R	L	3	5	5	3	\$ 118.12	\$ 20.33	\$ 77.25	\$ 12.50	\$ 32.86	\$ 195.34	\$ 12.00	\$ 207.34
132	HB	R	S	2	4	5	2	\$ 92.07	\$ 19.58	\$ 65.58	\$ 8.44	\$ -	\$ 185.67	\$ -	\$ 185.67
133	FS	R	S	4	3	4	4	\$ 75.66	\$ 20.33	\$ 73.53	\$ 6.72	\$ 28.57	\$ 147.67	\$ 2.00	\$ 149.67
134	FS	U	S	2	4	5	2	\$ 108.88	\$ 20.33	\$ 73.38	\$ 11.64	\$ 50.17	\$ 164.06	\$ -	\$ 164.06
135	FS	U	S	1	1	3	1	\$ 81.82	\$ 20.33	\$ 74.85	\$ 8.97	\$ 16.64	\$ 169.33	\$ -	\$ 169.33
136	HB	R	L	1	3	5	1	\$ 134.47	\$ 20.33	\$ 55.64	\$ 11.05	\$ 71.56	\$ 149.93	\$ -	\$ 149.93
137	FS	R	S	2	4	3	2	\$ 65.77	\$ 19.66	\$ 52.47	\$ 0.54	\$ -	\$ 138.44	\$ -	\$ 138.44
138	FS	R	S	0	0	0	0	\$ 164.94	\$ 20.33	\$ 74.02	\$ 15.28	\$ 144.33	\$ 130.24	\$ -	\$ 130.24
139	FS	R	S	5	4	4	5	\$ 79.49	\$ 20.33	\$ 67.96	\$ 11.73	\$ 15.40	\$ 164.11	\$ 6.00	\$ 170.11
140	FS	R	L	4	4	3	4	\$ 83.85	\$ 20.33	\$ 70.27	\$ 7.26	\$ 14.76	\$ 166.95	\$ 3.00	\$ 169.95

Figure 4: Rate Model Rate List Worksheet



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### Scenarios Comparison

One more worksheet, the Scenarios Comparison tab, was included for users in the model. The intent of this worksheet was to create a way for users to make side by side comparisons of different combinations of rate parameter settings. The worksheet lists the parameter settings for each cost center as well as statistics for value based purchasing and overall rate calculations. These settings and statistics are shown in different columns for each combination of rate setting parameter options. Two sets of default settings were included in the worksheet; one for the current methodology with an overall rate increase limit of 8%, and one for the same methodology without an overall rate increase limit. In the column next to the default settings is a list of modeled parameters. This column reflects the settings and outcomes produced by the current options selected on the Parameters and Analysis tab. The worksheet also includes two columns where users can copy and paste the modeled parameters so that they can be saved and compared to other combinations of rate setting options. Users were instructed to use these columns to save their preferred rate setting options.



## Reimbursement Model

### Scenarios Comparison Worksheet

South Dakota Nursing Facility Case Mix Rate Model					Date:	
Parameter Settings Scenarios Comparison					Reviewer:	
		Scenarios				
Rate Area	Parameter	Current w/ 8% Inc Limit	Current w/out Inc Limit	Modeled Parameters	Preferred Option 1	Preferred Option 2
General	Inflation Index	CPI	CPI	CPI		
	Inflation Through Date	12/31/2020	12/31/2020	12/31/2020		
	Small Facility Bed Ct	60	60	60		
Direct Care	Type of Rate	Cost - Ceilings	Cost - Ceilings	Cost - Ceilings		
	Occupancy Rule	Y	Y	Y		
	Overall CMI Calc.	Exclude Mdcr	Exclude Mdcr	Exclude Mdcr		
	Medicaid CMI Source	2018	2018	2018		
	Exclude CMI <1.0 from Limit	Y	Y	Y		
	Max Ceiling Rate	125%	125%	125%		
	Min Ceiling Rate	115%	115%	115%		
General Admin	Type of Rate	Cost - Ceilings	Cost - Ceilings	Cost - Ceilings		
	Occupancy Rule	Y	Y	Y		
	Include with NDC	N	N	N		
	Exclude CMI <1.0 from Limit	Y	Y	Y		
	Exclude Chains	Y	Y	Y		
	Max Ceiling Rate	110%	110%	110%		
	Min Ceiling Rate	105%	105%	105%		
Combined NDC	Type of Rate	Cost - Ceilings	Cost - Ceilings	Cost - Ceilings		
	Occupancy Rule	Y	Y	Y		
	Exclude CMI <1.0 from Limit	Y	Y	Y		
	Max Ceiling Rate	110%	110%	110%		
	Min Ceiling Rate	105%	105%	105%		
Capital	Type of Rate	Current	Current	Current		
Value Based	Est. Fiscal Impact	\$0	\$0	\$1,887,863		
Purchasing	Percent of Total Expend.	0.00%	0.00%	1.05%		
Overall	Impose Increase Limit	Y	N	Y		
	Increase Limit Percentage	8%	0%	8%		
	Estimated Cost	\$177,837,441	\$205,865,739	\$179,983,074		
	Weighted Avg. Rate	\$169.99	\$196.79	\$172.05		
	Average Cost Coverage	84.87%	97.76%	84.98%		
Notes	Record further explanation of base and VBP parameters modeled.	Calculates rebased rates using the current NF rate methodology.	Calculates rebased rates using the current NF rate methodology without the 8% overall rate increase limit.	Calculates rebased rates using the current NF rate methodology and a VBP add-on based on 5-Star staffing and QM scores with exclusions for health inspection ratings below 3.		

Figure 5: Rate Model Scenarios Comparison Worksheet



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There are several other worksheets within the rate model where the actual rate calculations and statistics are computed. However, these worksheets were not shared with all users in order to ensure the rate calculations were not altered. Only the Department staff were granted access to these worksheets so that they could review the rate calculation formulas.



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# Stakeholder Workgroup

## Overview and Membership

Myers and Stauffer worked in coordination with the DHS Long-Term Services and Supports staff to lead a workgroup composed of industry representatives and other stakeholders to evaluate the current methodology, consider relevant variables, and develop recommendations for changes to the nursing facility reimbursement methodology. The workgroup consisted of 26 members including 15 industry representatives, six DHS staff, three staff from other state agencies, and three consultants from Myers and Stauffer. The industry representatives included a broad range of nursing facility leaders representing for-profit and not-for-profit providers, sole proprietors and chain operations, rural and urban facilities, facilities based in hospitals, facilities that are part of continuing care retirement communities, and facilities that only provide nursing home care. Representatives were included from all regions of South Dakota. For a complete listing of all workgroup members please see Appendix B.

The group met ten different times between October 10, 2019 and June 3, 2020. Prior to each meeting, an agenda and supporting documents were sent to stakeholders. At the beginning of every meeting roll call was conducted. Following each meeting draft minutes were circulated to share a written record of the workgroup discussion. Beginning with the second meeting, a request for changes to the minutes from the prior meeting to be submitted by email to SDHS or Myers and Stauffer was made. That feedback was used to compile final minutes that were posted to the DHS website to provide a public record of the workgroup's activities. During each meeting an overview of the rate model and rate parameters or any changes that were implemented since the last meeting were presented. The following paragraphs provide a general summary of each of the workgroup meetings. Complete minutes from each meeting are included are available on the DHS website.

## Meeting Summaries

### **October 10, 2019**

Meeting was held at AmericInn, Fort Pierre, SD at 10:00 a.m. CST. Many stakeholders opted to attend via conference call due to the weather. Some background on the purpose of the workgroup was provided. The goals and objectives were explained as well as the project outline. A presentation of the current methodology was conducted and concerns regarding PDPM were raised. Strengths and weaknesses were discussed regarding the current methodology. Next a walk through the decision matrix discussing what items on the decision matrix should be retained as points for further discussion. The South Dakota Quality Measures (QM) Report was reviewed. Group decided to hold bi-weekly conference calls on Wednesdays from 11-12:30 CST.

### **November 6, 2019**



Meeting was held via Webinar and Conference Call at 11:00 a.m. CST. The rate model was demonstrated via Webinar and was mainly looking for feedback on the model. Options to choose between CPI or DRI inflation tables, adjust the through date or even exclude costs from inflation were modeled. Some of the Direct Care options modeled were choosing from current methodology to cost-limit or a priced based calculation. The model will display statistics such as the number of facilities impacted by the limit and statistics by various groups. Case Mix Index (CMI) data from 2018 or 2019 can be used. The remaining costs centers, General Administration, Other Operating and Capital costs were demonstrated in the model. Cost center assignment can be changed to which cost center each line item from schedule A is assigned too and whether to apply inflation to it. Members expressed concerns with capital reimbursement. Adjustments to the rate model will be made based on group feedback.

### **November 13, 2019**

Meeting was held via Webinar and Conference Call at 11:00 a.m. CST. The purpose of the rate study workgroup was revisited. General changes to the rate model were made to add information to the summary sheet. Lower cost coverage for large urban facilities prompted a discussion of electronic medical records and the impact to the facilities. It was determined that a survey could be helpful in determining how certain costs could impact the rate. The cost centers Health and Subsistence, Other Operating and Plant Operating are grouped together as Combined Non-Direct Care on the summary sheet. Value Based Purchasing (VBP) options were discussed. A comprehensive list of nursing facility VBP options was provided that identified three types of measures, Quality of Care, Quality of Life, and Other Measures.

### **November 20, 2019**

Meeting was held via Webinar and Conference Call at 11:00 a.m. CST. Changes to the rate model included calculating FY 2021 rates with and without the 8% increase limit. Inflation was changed to 12/31/2021. A worksheet with VBP options was added to the rate model. Data used in the rate model for VBP was “dummy” data to show how model works. A discussion on Property reimbursement included lease limits and if it impacts rates. A current capital limit of \$17.92, related party leases and new construction were discussed. Questions for the rate study survey were reviewed and suggestions were made to clarify the intent. The rate model will be shared with members with only “green” cells available for changing. Any scenarios a member would like to share can be saved in the new tab and discussed at the next meeting. Proposed content of the Legislative Report was reviewed and an estimated timeline suggested.

### **December 4, 2019**

Meeting was held at RedRossa Italian Grille in Pierre, SD and via Webinar and Conference Call at 10:30 a.m. CST. Received one survey back and suggestions were made to increase participation. Associations should let homes know the importance of the survey and sending an email every week is a couple of the suggestions. A walk-through the rate model discussing the rate parameters was conducted. Additional review of the VBP options was discussed. Health inspections tied to VBP makes some members nervous. An outline of the Legislative report was proposed. Target is to get to Legislature by middle of January.

### **December 18, 2019**



Meeting was held via Webinar and Conference Call at 11:00 a.m. CST. Twenty-five completed surveys have been received. That is 25% of the total sent out. Myers and Stauffer has not started tabulating the data and will provide a report at next meeting. A reminder to complete the survey should be sent out to homes by the associations. A walk-through of the rate model was conducted demonstrating the changes. A Scenarios comparison worksheet was added to the rate model and members were encourage to work with the model. The proposed timeline and content for the Legislative Report was reviewed.

### **January 8, 2020**

Meeting was held via Webinar and Conference Call at 11:00 a.m. CST. Analysis of the survey will begin soon. Was hoping to get at least 50% participation. A couple of facilities requested to send it in late. Discussion on the rate parameters continued. Requests to remove the 8% overall rate limit and remove ceiling from the Direct Care Costs. Model will be updated to identify the Access Critical Facilities and their rate methodology. Clarification on what the Legislative Report is to be was determined.

### **January 29, 2020**

Meeting was held at Drifters in Ft. Pierre, SD and via Webinar and Conference Call at 11:00 a.m. CST. No additional survey responses were received. Analysis of the survey responses was presented. Challenges to why surveys were not submitted and if a request for additional surveys should be made were discussed. There was discussion of the possibility of reimbursement falling behind in capital lease costs and medical director costs. The rate model was updated to include the Critical Access facilities and 638 facilities. A few suggestions for modeling different property options were discussed. Extraordinary Care expenditures were reviewed. It would eliminate the administrative burden if the process could be streamlined. Review of the current RUG categories will be reviewed to determine if it can be used. Also, BIMs score or CPS score maybe used for the behavioral health group. Discussion regarding PDPM implementation and an Optional State Assessment (OSA) could be used to model for PDPM. An appeal could be made to keep section G on the OBRA assessments.

### **February 26, 2020**

Meeting was held via Webinar and Conference Call at 11:00 a.m. CST. A cost-limit option for the property reimbursement was discussed. Rate model will calculate using either the limit or ceiling. Rebasing would encourage new construction where appropriate and promote access to care. Also noted was that cost report data has costs associated with old buildings and it would take too long to recover costs for improvements. Fair Rental Value (FRV) is one option to determine what current costs should be. MDS analysis for Extraordinary Care payments did not show a correlation between current payments and the data. Intent is to make it objective instead of requesting additional documentation. Changing to MDS data may have significant impact to some facilities. A plan to bridge OSAs for PDPM implementation was discussed.

### **June 3, 2020**

Meeting was held via Webinar and Conference Call at 11:00 a.m. CST. A summary of the work completed by Myers and Stauffer and the Department since the last workgroup meeting was



discussed. A review of the draft report outline for the final report was conducted. The limit options were presented in three scenarios. The analysis compared the fiscal impact of the different options for Direct Care, General Administrative, and Non-Direct Care. One scenario involved the current methodology with rebasing, a second scenario involved moving to a single limit with an overall budget neutral outcome, and a third scenario included a single limit set at the maximum ceiling percentage under the current methodology. Impact to facilities was minimal in each case. Property reimbursement options were discussed and included current reimbursement rates, current methodology with rebasing, updated limit methodology with rebasing, and a rudimentary fair rental value system. Options for standardizing the additional pay for Extraordinary Care were presented. The goal of creating a more objective and consistent methodology would eventually reduce administrative burdens for both facilities and state regulators. A Value Based Purchasing Model Template was reviewed. Various options were presented such as, reductions to incentives based on CMS Five-Star rating, rating for staffing and quality measures. Funding options for VBP were also discussed. CMS announced plans to continue gathering Section G data on quarterly and annual non-Medicare OBRA assessments in a memo titled PDPM Calcs Using OBRA Assessments. The State may continue to make RUGS calculations without the use of OSAs. Some analysis for comparing PDPM to RUGs could be completed as early as the first quarter of 2021.



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# Patient Driven Payment Model

Addressing the implications of the new CMS Patient Driven Payment Model (PDPM) was one of the primary tasks identified for this project. Although CMS implemented this new system for the Medicare reimbursement program, there are related policy decisions that could have a direct impact on the South Dakota Medicaid nursing home reimbursement system. The circumstances regarding PDPM changed multiple times throughout the course of the rate review. This situation forced the Department to formulate and later amend plans to address the changing CMS policies. As of this writing, the data necessary to continue the current Resource Utilization Groups (RUG)-based resident-specific acuity adjustment is expected to be available through at least September 30, 2021. Beginning October 1, 2020, the Department will also have the ability to begin accumulating PDPM data for all nursing facility residents. This will allow for initial analysis comparing PDPM acuity measures to RUG acuity measures to occur as early as January of 2021. However, it will take much longer to accumulate the data necessary to complete a thorough analysis of PDPM options. This analysis needs to be completed before a thoughtful transition to PDPM can be completed. Ideally this transition would not occur until July 1, 2023 or after. However, the Department could possibly move to PDPM sooner just with less certainty about the potential impact. The sections that follow provide a summary of the different circumstances that the Department has attempted to mitigate with its PDPM implementation plans.

## Initial PDPM Implementation Plan

The Department's initial PDPM implementation plan was developed with the understanding that the primary implications for the South Dakota Medicaid nursing home reimbursement system were that a considerable amount of Medicare assessment data would cease to be collected beginning October 1, 2019, and system data needed to calculate RUGs classification codes would no longer be included in the MDS data set as of October 1, 2020.

The concern over the reduction in Medicare assessment data stemmed from the CMS plan to eliminate follow-up assessments and utilize only five-day assessments for PDPM. Because data from all assessments is used to establish a base acuity measure in the South Dakota payment system, there was concern that the elimination of the Medicare follow-up assessments could distort overall acuity calculations. CMS recognized that removing these assessments might impact Medicaid programs and therefore provided an alternative way for states to capture additional assessment data. That alternative involved the use of Optional State Assessments (OSA) to take the place of the follow-up assessments being eliminated. To estimate the potential impact of removing the follow-up assessment data we calculated average case mix values using current assessment information both with and without the Medicare follow-up assessments. We determined that the impact of removing those assessments would likely be very minimal, most likely resulting in a change in the overall CMI of less than 2%. This analysis is



shown in the table below. Based on this analysis it was determined that utilizing OSAs to capture additional assessment information would not be beneficial.

**Table 1: Impact of Removing Medicare Follow-Up Assessments on Overall CMI**

Period	All Residents CMI Before		All Residents CMI After		Change in CMI	
	Assessment Count	Average CMI	Assessment Count	Average CMI	Average CMI	% Change
Quarter 1 2018	5,411	1.1900	5,411	1.2096	0.0196	1.64%
Quarter 2 2018	5,197	1.1600	5,197	1.1776	0.0176	1.52%
Quarter 3 2018	5,069	1.1700	5,069	1.1951	0.0251	2.14%
Quarter 4 2018	4,941	1.1700	4,941	1.1946	0.0246	2.10%
Total CY 2018	20,618	1.1725	20,618	1.1942	0.0217	1.85%

Addressing the second issue of RUG data elements being removed from the assessment data created greater concern since the plan CMS announced did not provide for a transition period where states could evaluate both existing RUG based acuity adjustments and PDPM based adjustments. The OSA again provided an opportunity for states to capture additional data to take the place of information CMS would no longer collect. Therefore the Department adopted the plan to require OSAs to be completed for all assessments beginning July 1, 2020. The OSAs would be used to capture all of the current MDS Section G questions and a few other data elements that are necessary to compute RUG classifications. This plan evolved through multiple discussions between Myers and Stauffer, the DHS LTSS staff, and the other members of the Stakeholder Workgroup. At the time it, this option appeared to be the only way to continue the resident-specific RUG based acuity adjustments that are a core component of the South Dakota nursing home reimbursement system.

## Revised PDPM Implementation Plan

The revised PDPM implementation plan was developed once CMS announced that the proposed changes to the MDS data elements for October 1, 2020 would not be implemented and therefore the information needed for RUG classifications would continue to be collected on all MDS assessments. Since CMS traditionally makes adjustment to the MDS data set just once each year effective with the start of the federal fiscal year, it appears this current situation may continue through at least September 30, 2021. CMS has also given states the option to begin collecting the data elements needed for PDPM calculations on most non-Medicare assessments beginning October 1, 2020. This data is currently collected on only the Medicare assessments. With this option states will now have the ability to capture the data necessary to make PDPM classification calculations for all South Dakota nursing facility residents. Although it will take several months to accumulate enough data to analyze implementing a PDPM based acuity adjustment process for the South Dakota system, this current circumstance does put the State in a much better position to consider that transition.



These more recent developments triggered a re-evaluation of the initial PDPM implementation plan and eventually led to a revised plan. Collecting OSAs to capture section G and other RUG data no longer provided a benefit since that data will now continue to be captured through the regular assessment process. The option to add PDPM data elements to non-Medicare assessments beginning October 1, 2020 also protects the State's ability to begin analyzing PDPM acuity information on the same timeline that was anticipated. Therefore the Department adopted a plan to continue the current RUG based acuity adjustments, add the PDPM data elements to non-Medicare assessments on October 1, 2020, and begin analysis of PDPM acuity information in January of 2021. The Department will continue with RUG based acuity adjustments until that option can no longer be supported or until a thorough analysis of transitioning to PDPM can be completed.



# Analysis and Findings

## Analysis of Current Methodology

Myers and Stauffer built the Rate Model to first mirror the calculation of rates using the current rate methodology. We worked with LTSS staff to ensure the rate calculations performed as expected. This effort provided the ability to calculate rebased rates using the current rate parameters. This established a baseline for comparing other rate parameter options.

Rates were calculated for FY 2022 under the current reimbursement methodology in order to establish a baseline for rebasing rates under the current methodology. Cost data from each provider's fiscal year ending in 2018 was used. The data was inflated to the midpoint of the FY 2022 rate period, which is December 31, 2021. The tables presented in this section show the general settings used for the modeled rate calculations, the specific rate parameters used for each cost center, and the overall rate parameters applied to the calculation.

The tables also show statistics that can be used to help evaluate the impact of the rate methodology. These statistics include the weighted average per diem rate, the maximum rate, the minimum rate, the average cost coverage, and the number of facilities impacted by the cost center ceilings. The analysis is broken apart for each cost center so that the impact to each cost center can be reviewed. There is also a section for general settings and overall analysis. The following tables are included; General Rate Parameters, Direct Care Cost Center Parameters and Analysis, General Administrative Cost Center Parameters and Analysis, Combined Non-Direct Care Parameters and Analysis, Capital Cost Center Parameters and Analysis, and Overall Rate Parameters and Analysis.

The Overall Rate Parameters and Analysis table shows the same statistics that are presented for each of the cost centers but also includes a pro forma calculation showing the total estimated gross cost of rebasing. This total cost estimate is calculated by summing the products of each facility's estimated rate and their estimated days. This total is not adjusted for client charges paid directly to the facility that reduce the State's actual expenditures. The total also does not include other program expenditures for swing beds, extraordinary care, crossover payments, or add pays. It is simply the total estimated cost of the calculated per diem rates.

## General Rate Parameters

The general rate parameters applied for the rebasing calculation included using the 2018 cost data, and applying inflation through December 31, 2021 using the CPI index. A total of 101 facilities were included



in the modeling, including 19 hospital based facilities and 82 free standing facilities. Statistical analysis is also provided for urban (26) and rural (75) facilities, small (65) and large (36) facilities, as well as access critical facilities (9), and one 638 facility.

**Table 2: General Rate Parameters for Rebasing FY 2022 Rates**

General													
Cost Report Data for Fiscal Years Ending in:				Rate Analysis Groupings:									
				HB/FS: Hospital Based (shared costs with hospital) vs. Free Standing Facilities									
Inflation Options:				U/R: Urban (within OMB defined CBSA) vs. Rural									
Index:				S/L: Small vs. Large Facilities									
Through Date:				Small Facilities are < or =									
				60 beds									
Rate comparison Options:				Analysis Group:									
Fiscal Year:													
				All	HB	FS	U	R	S	L	AC NFs	638 NFs	
				Count:	101	19	82	26	75	65	36	9	1

### Direct Care Cost Center Parameters and Analysis

For the Direct Care cost center the type of rate modeled is the current cost-based rates with two ceilings, referred to in the model as Cost-Ceilings. The current occupancy rule was applied. The overall CMI calculation excluded Medicare. The Medicaid CMI calculation used 2020 data. The maximum ceiling was set at 125% of the median cost and came to \$18.14. The minimum ceiling was set at 115% of the median and came to \$99.49. Providers with a CMI less than 1.0 were excluded from the median array used to calculate the ceilings. Costs for Access Critical and 638 facilities were not subject to cost ceilings.

The rebasing analysis showed that the weighted average Direct Care per diem calculated out to \$98.87, with the maximum per diem coming in at \$181.96 and the minimum per diem being \$61.03. Average cost coverage for Direct Care costs is 97.99%. There are 14 facilities impacted by the maximum ceiling and 22 impacted by the minimum ceiling. Cost coverage for hospital based facilities is 95%, but cost coverage exceeded 97% for all other facility groups.

**Table 3: Direct Care Cost Center Parameters for Rebasing FY 2022 Rates**

Direct Care																
Type of Rate:		Occupancy Rule:		Rate Analysis				All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Ceilings		Y		Wtd. Avg. Rate:				\$101.16	\$113.08	\$ 98.68	\$105.18	\$ 99.64	\$ 94.17	\$107.40	\$104.65	\$ 94.67
				Maximum Rate:				\$186.17	\$186.17	\$145.39	\$145.39	\$186.17	\$186.17	\$145.39	\$186.17	\$ 94.67
				Minimum Rate:				\$ 62.44	\$ 64.49	\$ 62.44	\$ 73.37	\$ 62.44	\$ 62.44	\$ 80.24	\$ 64.49	\$ 94.67
CMI Data Options:				Average Cost Coverage:				97.99%	95.01%	98.61%	98.20%	97.91%	99.37%	96.75%	100.00%	100.00%
Overall CMI Calculation		Exclude Mdc		Facilities Impacted by Max Limit				14	5	9	4	10	5	9	0	0
Medicaid CMI Source		2020		Facilities Impacted by Min Limit				22	7	15	9	13	8	14	0	0
Ceiling/Limit/Price Calculations:																
Median		\$ 88.52		Special Limits/Ceilings				Maximum Rate @ CMI 1.0:								
Max. Ceiling/Limit/Price		125% \$ 110.65		AC NFs: 100% of costs.				\$108.88								
Min. Ceiling		115% \$ 101.80		638 NFs: 100% of costs.												
Exclude CMI < 1.0:		Y														



### General Administrative Cost Center Parameters and Analysis

For the General Administrative cost center the type of rate modeled for FY 2022 rebasing was the current methodology with rates based on costs and two ceilings applied to rate calculations. The occupancy rule was applied to this cost center. The model included the option to group General Administrative costs together with other non-direct costs but that was not selected for the rebasing model. The maximum ceiling was set at 110% of the median cost and came to \$20.52. The minimum ceiling was set at 105% of the median cost putting it at \$19.58.

The statistical analysis of the General Administrative rate modeling showed that the average per diem rate for this cost center would be \$19.55, with a maximum rate of \$32.88 and a minimum rate of \$10.85. There are 73 facilities that would be impacted by the maximum ceiling, and 76 that would be impacted by the minimum ceiling. The average cost coverage would be 73.97% for this cost center. Cost coverage would be lowest for urban facilities, coming in at 65%.

**Table 4: General Administrative Cost Center Parameters for Rebasing FY 2022 Rates**

General Administrative														
Type of Rate:		Occupancy Rule:		Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Ceilings		Y				\$ 20.00	\$ 19.12	\$ 20.18	\$ 20.41	\$ 19.84	\$ 19.83	\$ 20.15	\$ 18.77	\$ 33.64
Other Rate Options:		Include with Non-Direct		Wtd. Avg. Rate:		\$ 33.64	\$ 20.80	\$ 33.64	\$ 20.80	\$ 33.64	\$ 33.64	\$ 20.80	\$ 20.03	\$ 33.64
				Minimum Rate:		\$ 11.10	\$ 11.10	\$ 13.97	\$ 14.10	\$ 11.10	\$ 11.10	\$ 14.08	\$ 11.10	\$ 33.64
				Average Cost Coverage:		73.97%	77.51%	73.23%	65.28%	77.24%	78.14%	70.24%	74.85%	100.00%
				Facilities Impacted by Max Limit		73	12	61	22	51	45	28	7	0
				Facilities Impacted by Min Limit		76	12	64	23	53	46	30	7	0
Ceiling/Limit/Price Calculations														
Median			\$ 19.08	Special Limits/Ceilings		Maximum Rate:								
Max. Ceiling/Limit/Price		110%	\$ 20.99	AC NFs: 105% of median.		\$ 20.03		\$ 20.80						
Min. Ceiling		105%	\$ 20.03	638 NFs: 100% of costs.										
Exclude CMI < 1.0:		Y												
Exclude Chains		Y												

### Combined Non-Direct Care Parameters and Analysis

For the Combined Non-Direct Care cost center rates were calculated using a cost-based calculation with two ceilings reflecting the current reimbursement methodology. The occupancy rule was applied to these costs. A maximum ceiling was set at 110% of the median cost and came to \$78.18. A minimum ceiling was set at 105% of the median costs resulting in \$74.62.

The statistical analysis of the Combined Non-Direct Care rate calculations showed that the average rate would be \$68.66, with a maximum rate of \$77.47, and a minimum rate of \$42.35. The average cost coverage for all facilities in this cost center came to 96.31%. There would be 24 facilities impacted by the maximum ceiling and 34 impacted by the minimum ceiling. Hospital based facilities had the lowest cost coverage statistic at 91%.



**Table 5: Combined Non-Direct Care Cost Center Parameters for Rebasing FY 2022 Rates**

Combined Non-Direct Care												
Type of Rate:	Occupancy Rule:	Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Ceilings	Y	Wtd. Avg. Rate:		\$ 70.26	\$ 74.44	\$ 69.39	\$ 68.77	\$ 70.82	\$ 68.87	\$ 71.50	\$ 71.66	\$ 78.28
		Maximum Rate:		\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 78.28
		Minimum Rate:		\$ 43.34	\$ 56.93	\$ 43.34	\$ 52.08	\$ 43.34	\$ 43.34	\$ 52.08	\$ 58.11	\$ 78.28
		Average Cost Coverage:		96.31%	90.98%	97.42%	98.56%	95.47%	97.31%	95.42%	94.74%	99.40%
		Facilities Impacted by Max Limit		24	10	14	2	22	13	11	4	0
		Facilities Impacted by Min Limit		34	14	20	7	27	21	13	4	1
Ceiling/Limit/Price Calculations												
Median		\$ 72.74	Special Limits/Ceilings		Maximum Rate:							
Max. Ceiling/Limit/Price	110%	\$ 80.01	AC NFs: 105%	of median.	\$ 76.38	\$ 79.28						
Min. Ceiling	105%	\$ 76.38	638 NFs: 100%	of costs.								
Exclude CMI < 1.0:	Y											

## Capital Cost Center Parameters and Analysis

The rate components for the Capital cost center were determined using the current capital per diems. This included applying the current ceiling of \$17.62.

The statistical analysis of the modeled Capital rate components shows that the average Capital per diem would be \$10.96. The maximum Capital per diem would be \$17.62, and the minimum Capital component would be \$0.54. There would be 19 facilities that would be impacted by the ceiling for the Capital cost center. The average cost coverage for the modeled Capital rates was 93.25%. Large nursing facilities (greater than 60 beds) would have the lowest cost coverage statistic at 90%.

**Table 6: Capital Cost Center Parameters for Rebasing FY 2022 Rates**

Capital																
Type of Rate:				Rate Analysis				All	HB	FS	U	R	S	L	AC NFs	638 NFs
Current				Wtd. Avg. Rate:				\$ 10.96	\$ 8.31	\$ 11.51	\$ 12.41	\$ 10.41	\$ 8.69	\$ 12.98	\$ 8.98	\$ 3.91
				Maximum Rate:				\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 3.91
				Minimum Rate:				\$ 0.54	\$ 1.29	\$ 0.54	\$ 3.13	\$ 0.54	\$ 0.54	\$ 3.50	\$ 1.29	\$ 3.91
				Average Cost Coverage:				93.25%	94.66%	92.96%	91.90%	93.76%	97.21%	89.73%	90.43%	100.00%
				Facilities Impacted by Limit				19	3	16	7	12	7	12	2	0
Ceiling/Limit/Price Calculations																
Median			\$ 10.91	Special Limits/Ceilings				Maximum Rate:								
Max. Ceiling/Limit	160%		\$ 17.62	AC NFs:	105%	of median.	\$ 11.46					\$ 17.62				
Min. Ceiling			NA	638 NFs:	100%	of costs.										

## Overall Rate Parameters and Analysis

There is a limit applied to the total calculated rates. For regular nursing facilities this limit is 8%. The rebased rates for these facilities could not exceed 108% of the previous rate. The limit increase is raised to 10% for AC NFs and 638 NFs.

The statistical analysis for the overall rates showed that the weighted average rate would be \$171.27. With 998,827 Medicaid days projected for FY 2022, this would result in total estimated costs of \$171,073,869. This estimate is not adjusted to account for client charges paid directly to facilities. Those payments would reduce the cost incurred by the State. Nor does it include allowances for swing bed payments, extraordinary care payments, crossover payments, or add pay payments.



The maximum calculated rate for this methodology was \$225.17. The minimum calculated rate was \$127.27. There are 91 facilities that would be limited by the cap on overall rate increases. Overall cost coverage came to an average of 85.16%. Hospital based providers and large nursing homes would have the lowest cost coverage at 83% for each group.

**Table 7: Overall Parameters for Rebasing FY 2022 Rates**

Overall Analysis														
Estimated Fiscal Impact			Rate Analysis											
Wtd. Avg. Rate	\$	171.57	Wtd. Avg. Rate:			All	HB	FS	U	R	S	L	AC NFs	638 NFs
Medicaid Days		998,827	Maximum Rate:			\$171.57	\$184.78	\$168.82	\$172.82	\$171.10	\$167.05	\$175.60	\$191.09	\$210.50
Estimated Cost	\$	171,365,999.89	Minimum Rate:			\$225.37	\$225.37	\$210.99	\$210.99	\$225.37	\$225.37	\$201.81	\$225.37	\$210.50
Estimated VBP Payments	\$	1,874,240.00	Average Cost Coverage:			\$127.27	\$137.98	\$127.27	\$127.27	\$129.42	\$127.27	\$142.42	\$137.98	\$210.50
Total Wtd. Avg. Rate	\$	173.44	Facilities Impacted by Increase Limit:			93	17	76	26	67	57	36	4	0
Impose Increase Limit:			Reg NF Increase Limit %:			AC NF Increase Limit %:			638 NF Increase Limit %:					
Y			8%			10%			10%					

This initial modeling task accomplished two things. First it provided an estimated cost of rebasing for FY 2022. Second it established a baseline for evaluating the fiscal impact of other rate setting options. The total estimated cost of the FY 2022 per diem rates calculated under this model came to \$171,366,000. This would result in a cost savings of \$2,921,788 compared to the total estimated costs of the FY 2021 per diem rates of \$174,287,788. The estimated cost of the FY 2022 can also be used as a base cost to determine the fiscal impact of other rate setting options.



### Strengths and Weaknesses of the Current Methodology

One of the discussion items for the first meeting of the Stakeholder Workgroup was strengths and weaknesses of the current South Dakota Medicaid nursing facility reimbursement system. Members were asked to share their views on the strengths and weaknesses of the current rate setting methodology. The resident-specific acuity adjustment was the most commonly cited strength of the reimbursement system. Other strengths that were noted included on-time payments, the bed hold policy for therapeutic and hospital stay days, and the incorporation of therapy into Direct Care.

Comments about the weaknesses of the current methodology were much more varied and extensive. One area cited as a weakness by multiple workgroup members is the current capital reimbursement. One workgroup member noted that the capital reimbursement component of the rates has not lead to the replacement of aging facilities and that the average age of nursing facility buildings in the state is now 47 years. Other workgroup members stated that capital costs are not adequately realized, and that lease costs are not recognized. Other weaknesses to the system that were noted included; cost center limits that may be too narrow leading to rates getting further and further away from actual costs, technology costs that are not realized, not having a provider tax, the awkward process for extraordinary care payments, and Alzheimer's/other memory care patient that are not adequately recognized by the case mix system. The fact that rates have not been rebased in many years contributes heavily to many of these issues especially the concern that the rates seem to be getting further and further away from actual costs and that they fail to realize current technology costs.

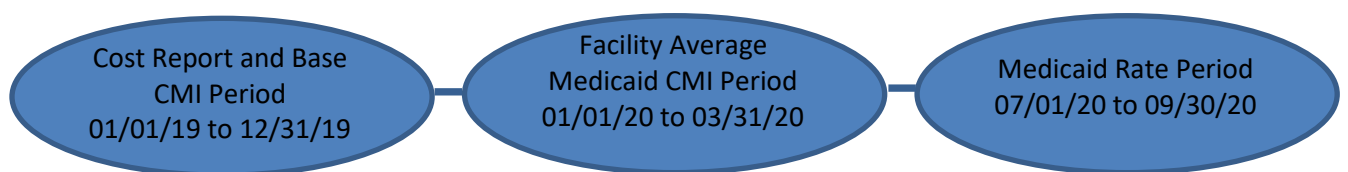
These comments helped to shape the analysis that Myers and Stauffer completed. Almost every one of the weaknesses noted was studied through the rate review. In some cases that analysis evolved into recommendations that are included in the Recommendations section of this report.

Although the strengths that were noted did not always trigger additional analysis, some did provide noteworthy insight. In particular the resident-specific acuity adjustment is notable. This is likely the most sensitive Medicaid case mix system in the country. Most case mix systems rely on facility average case mix values established from data accumulated months in advance of the actual service date. In these systems a base rate is established from cost report and case mix data from the most recent fiscal year preceding the rate period. The rate for a particular calendar quarter is then established by adjusting the base rate to reflect more current Medicaid case mix information. However, there is usually a lag time of at least one quarter between the Medicaid case mix data period and the rate period. Furthermore these systems rely on facility average case mix calculations thus the payment rate may not match the acuity for any specific resident because it is calculated from a prior period and reflects the average Medicaid acuity rather than the acuity of the specific resident.



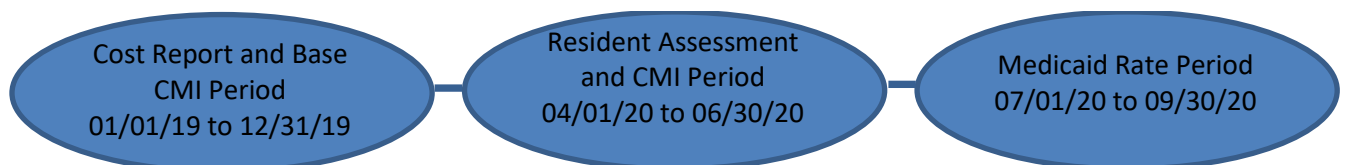
The South Dakota acuity adjustment is more specific and timely. It still relies on historical cost data and facility average case mix information from the most recent fiscal year to establish base rates. However, those rates are adjusted for each individual resident based on the most recent assessment available for that resident. This means that the payment rate for any specific resident reflects the acuity of that resident as determined by the most recent assessment completed for them. The figures below attempt to illustrate the differences between case mix systems that use facility average case mix data versus a resident-specific case mix system like South Dakota.

**Figure 6: Facility Average Case Mix System Example**



*In the example shown a base rate is established from the provider's most recent fiscal year cost report (01/01/19 to 12/31/19). The base rate is established relative to a case mix index (CMI) determined from case mix data that corresponds to the cost report period. That rate is then adjusted for the payment period (07/01/20 to 09/30/20) using a facility Medicaid average CMI calculated from case mix data for a quarter preceding the rate effective date (01/01/20 to 03/31/20). Throughout the payment period the CMI would remain fixed.*

**Figure 7: Resident-Specific Case Mix System Example**



*In this example a resident-specific case mix system a base rate is still established from the provider's most recent fiscal year cost report (01/01/19 to 12/31/19). The base rate is again established relative to a case mix index (CMI) determined from case mix data that corresponds to the cost report period. However, that rate is then adjusted for the payment period (07/01/20 to 09/30/20) using a resident specific CMI determined from information taken from the resident's most recent quarterly assessment (04/01/20 to 06/30/20). During the rate period the CMI would be updated to reflect any more current assessment completed for the resident.*

Resident-specific case mix systems are not without flaws. They do not allow the provider to review the case mix information used to determine the payment rate. They also require the facility to accept multiple payment rates from the Medicaid system. However, resident-specific case mix systems do reflect the most current case mix information available for each resident. This makes these systems more responsive to changes in acuity than a facility average case mix system and for that reason can be considered a strength of the South Dakota Medicaid nursing facility reimbursement program.



### Provider Surveys

During the initial Workgroup meeting some comments were shared about expenses that are not captured by the current cost report nor reflected in the reimbursement rates. The expenses identified included the cost of leases, the cost of electronic health records, and the cost of telehealth services. In order to gather additional information not collected in the Medicaid cost reports or available through other sources Myers and Stauffer developed a provider survey. The Workgroup provided additional input during the development of the survey questions and recommended that Medical Director costs also be gathered. The final survey included sections on information technology costs (including telehealth and electronic health records), capital lease costs, and Medical Director costs. A copy of the survey form is included in Appendix C.

### Information Technology Costs

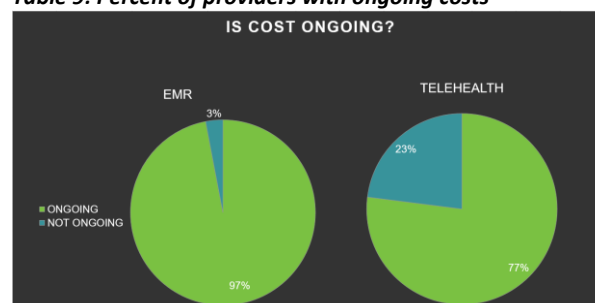
Providers were asked to report their electronic medical records (EMR) and telehealth costs. They were asked to report their one-time IT system and hardware costs for the 2017 and 2018 for EMR and telehealth separately. The costs reflected the initial purchase price of all hardware for EMR and telehealth. Providers were also asked to report the annual software lease costs per year over the last two years. The chart in Table 8 below, shows the average cost for the EMR and telehealth for each year. The EMR costs decreased slightly from 2017 to 2018 and telehealth cost more than doubled over the prior year.

**Table 8: Average EMR and Telehealth costs**

AVERAGE EMR AND TELEHEALTH COST		
	EMR	TELEHEALTH
2017	\$18,078	\$7,780
2018	\$15,614	\$18,692

Providers were asked to report if their 2018 software costs for EMR and telehealth are ongoing or not ongoing. The chart in table 9 below, shows the percentage that is ongoing and not ongoing for EMR and telehealth. The 2018 EMR costs are almost entirely ongoing and about three-fourths of the telehealth costs are ongoing.

**Table 9: Percent of providers with ongoing costs**





Providers were asked to report their IT system training costs per year over the last two year for EMR and telehealth. Included in the costs are initial and on-going costs. The chart in table 10 below, shows the average IT training costs separately for years 2017 and 2018. Thirteen responses were reported for EMR and eight for telehealth. The IT training costs have increased for both EMR and telehealth over the prior year.

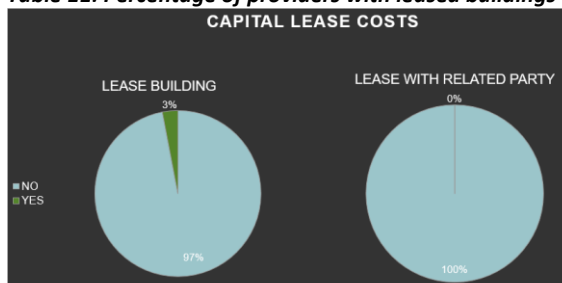
**Table 10: Average IT Training Costs**

Average IT Training Costs		
	EMR	TELEHEALTH
2017	\$1,626	\$4,125
2018	\$2,761	\$6,100

### Capital Lease Costs

Providers were asked to answer yes or no whether they lease the building and if so, if the lease is with a related party. Thirty-four providers responded. The chart in table 11 below, shows that ninety-seven percent of the providers responded that they own the building and out of the three percent that do lease did not lease from a related party.

**Table 11: Percentage of providers with leased buildings and percent with related party**



If providers leased their building, they were asked to list the annual lease costs for the last two years. Two providers responded. The chart in table 12 below, shows the average annual lease expense remained the same for 2017 and 2018.

**Table 12: Average annual lease costs**

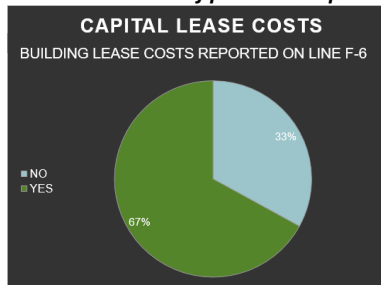
CAPITAL LEASE COSTS	
AVERAGE ANNUAL LEASE	
2017	\$87,719
2018	\$87,719

Next, providers were asked yes or no, if the lease costs are reported on the cost report on line F-6, Rent facility & Grounds. Three providers responded. The chart in table 13 below, shows sixty-seven percent



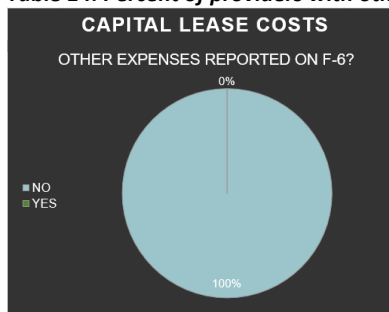
responded the building lease costs are reported on the cost report on line F-6 and thirty-three responded they are not.

**Table 13: Percent of providers reporting lease costs on cost report**



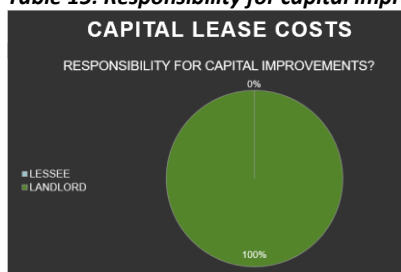
Providers were asked a yes or no question whether other expenses are also reported on the cost report in line F-6, Rent facility & Grounds. Three responses were completed. The chart in table 14 below, shows all three providers responded that other expenses are not reported on the cost report in line F-6, Rent facility & Grounds.

**Table 14: Percent of providers with other expenses reported on the costs report**



If providers leased their building, they were asked to identify if the Lessee or Landlord is the responsible party for capital improvements. Two providers replied. The chart in table 15 below, shows that both identified the Landlord is the responsible party.

**Table 15: Responsibility for capital improvements**





If the lessee is the responsible party then they were asked to report improvement costs for the last two years. Two responses were received, where one provider indicated zero costs. The chart in table 16 below, show the average capital improvement cost for the two years.

**Table 16: Average capital improvement costs**

Average Capital Improvement Cost	
	Average
2017	\$20,824
2018	\$12,399

### Medical Director Costs

Providers were asked to report the wages/salaries, taxes and benefits costs associated with the Medical Director, if they are a member of the staff at their facility, over the last two years. The chart in table 17 below, shows the average salary costs, contract fees, and other costs for Medical Directors. Nine surveys included responses for salary costs. The average salary cost increased by about one-third over the prior year. Thirty-four surveys included responses for contract fees. The average contract fee for Medical Directors decreased slightly over the prior year. The average other costs for Medical Director decreased significantly over the prior year with thirteen responses for 2017 and twelve for 2018. The last question on the survey requested providers to report their annual costs for other physician services (including telemedicine) over the last two years. Ten providers responded with zero expenses for both years.

**Table 17: Average Medical Director Costs**

Medical Director Costs	
Average Salary Costs	
2017	\$1,606
2018	\$2,167
Average Contract Fees	
2017	\$7,152
2018	\$6,690
Average Other Costs	
2017	\$314
2018	\$51
AVERAGE ANNUAL PHYSICIAN FEES	
2017	\$0
2018	\$0



## Reimbursement Parameters Reviewed

Myers and Stauffer built the Rate Model to enable users to evaluate different parameters within the rate setting methodology. This included the ability to adjust the type of rate calculation used for each cost center, the ability to turn the occupancy rule calculation on or off, the ability to adjust some parameters used in CMI calculations, the ability to set the percentage used to establish ceilings, the ability to group non-direct care costs together or keep them separated, and the ability to turn the overall increase limit on or off and to adjust the cap on the increase limit when it is applied. We demonstrated making adjustments to these parameters for the Workgroup. We also informed them that additional settings could be added to the model to incorporate any additional options they would like to investigate.

What follows are a couple of examples of how various options in the rate setting model could be used to explore changes to the rate setting methodology. These examples are presented just to illustrate the modeling capabilities provided to the Workgroup.

One of the key modeling options discussed was the ability to choose different types of rate calculations. For example for the General Administrative cost center three types of rates were included as options. The current methodology using a cost-based rate calculation with two ceilings was labeled as Cost-Ceilings. A second rate option included in the model was a cost based calculation using a single limit which was titled Cost-Limit. A final rate type option was Price, where a set price would be established for all providers for this cost center. The following tables show each of these three rate type options and the analysis generated by the model to enable users to evaluate each option.

**Table 18: Cost-Based Rate Calculation with Two Ceilings**

General Administrative											
Type of Rate:	Occupancy Rule:			Rate Analysis							
Cost - Ceilings	Y			Wtd. Avg. Rate:		\$ 20.00	\$ 19.12	\$ 20.18	\$ 20.41	\$ 19.84	\$ 19.83
				Maximum Rate:		\$ 33.64	\$ 20.80	\$ 33.64	\$ 20.80	\$ 33.64	\$ 20.15
				Minimum Rate:		\$ 11.10	\$ 11.10	\$ 13.97	\$ 14.10	\$ 11.10	\$ 11.10
Other Rate Options:				Average Cost Coverage:		73.97%	77.51%	73.23%	65.28%	77.24%	78.14%
Include with Non-Direct	N			Facilities Impacted by Max Limit		73	12	61	22	51	45
				Facilities Impacted by Min Limit		76	12	64	23	53	46
Ceiling/Limit/Price Calculations											
Median			\$ 19.08	Special Limits/Ceilings							
Max. Ceiling/Limit/Price	110%	\$ 20.99		AC NFs: 105%	of median.	\$ 20.03					
Min. Ceiling	105%	\$ 20.03		638 NFs: 100%	of costs.						
Exclude CMI < 1.0:	Y										
Exclude Chains	Y										



**Table 19: Cost-Based Rate Calculation with Single Limit**

General Administrative														
Type of Rate:		Occupancy Rule:		Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Limit		Y		Wtd. Avg. Rate:		\$ 20.19	\$ 19.43	\$ 20.35	\$ 20.58	\$ 20.05	\$ 20.07	\$ 20.31	\$ 19.54	\$ 33.64
Other Rate Options:		N		Maximum Rate:		\$ 33.64	\$ 20.99	\$ 33.64	\$ 20.99	\$ 33.64	\$ 33.64	\$ 20.99	\$ 20.99	\$ 33.64
				Minimum Rate:		\$ 11.10	\$ 11.10	\$ 13.97	\$ 14.10	\$ 11.10	\$ 11.10	\$ 14.08	\$ 11.10	\$ 33.64
				Average Cost Coverage:		74.60%	78.49%	73.80%	65.81%	77.92%	78.94%	70.73%	77.48%	100.00%
Facilities Impacted by Max Limit				73	12	61	22	51	45	28	7	0		
Facilities Impacted by Min Limit				0	0	0	0	0	0	0	0	0		
Ceiling/Limit/Price Calculations						Special Limits/Ceilings		Maximum Rate:						
Median		\$ 19.08												
Max. Ceiling/Limit/Price	110%	\$ 20.99	AC NFs:	105%	of median.	\$ 20.03	\$ 20.99							
Min. Ceiling	105%	NA	638 NFs:	100%	of costs.									
Exclude CMI < 1.0:	Y													
Exclude Chains	Y													

**Table 20: Price-Based Rate Calculation Set at the Median Cost**

General Administrative														
Type of Rate:		Occupancy Rule:		Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Price		Y		Wtd. Avg. Rate:		\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08
Other Rate Options:		N		Maximum Rate:		\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08
				Minimum Rate:		\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08	\$ 19.08
				Average Cost Coverage:		72.99%	81.62%	71.20%	62.29%	77.02%	78.34%	68.21%	81.86%	56.72%
Facilities Impacted by Max Limit				78	13	65	24	54	47	31	7	0		
Facilities Impacted by Min Limit				0	0	0	0	0	0	0	0	0		
Ceiling/Limit/Price Calculations				Special Limits/Ceilings		Maximum Rate:								
Median		\$ 19.08	AC NFs:		105%	of median.	\$ 20.03	\$ 19.08						
Max. Ceiling/Limit/Price	100%	\$ 19.08	638 NFs:		100%	of costs.								
Min. Ceiling	105%	NA												
Exclude CMI < 1.0:	Y													
Exclude Chains	Y													

Another rate setting option included for each cost center was the ability to adjust the limit calculation. The two tables that follow show the difference between setting a Direct Care rate using a single limit set at 125% of the median cost, versus setting that limit at 120% of the median cost.

**Table 21: Cost-Based Direct Care Rate with Single Limit at 125% of Median Cost**

Direct Care															
Type of Rate:		Occupancy Rule:		Rate Analysis			All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Limit		Y		Wtd. Avg. Rate:			\$101.49	\$113.82	\$ 98.92	\$105.58	\$ 99.94	\$ 94.29	\$107.91	\$104.65	\$ 94.67
CMI Data Options:				Maximum Rate:			\$186.17	\$186.17	\$145.39	\$145.39	\$186.17	\$186.17	\$145.39	\$186.17	\$ 94.67
				Minimum Rate:			\$ 62.44	\$ 64.49	\$ 62.44	\$ 73.37	\$ 62.44	\$ 62.44	\$ 80.24	\$ 64.49	\$ 94.67
				Average Cost Coverage:			98.23%	95.54%	98.78%	98.49%	98.12%	99.47%	97.12%	100.00%	100.00%
Overall CMI Calculation		Exclude Mdc		Facilities Impacted by Max Limit			14	5	9	4	10	5	9	0	0
Medicaid CMI Source		2020		Facilities Impacted by Min Limit			0	0	0	0	0	0	0	0	0
Ceiling/Limit/Price Calculations:															
Median				\$ 88.52		Special Limits/Ceilings			Maximum Rate @ CMI 1.0:						
Max. Ceiling/Limit/Price		125%		\$ 110.65		AC NFs: 100%			of costs. \$110.65						
Min. Ceiling		115%		NA		638 NFs: 100%			of costs.						
Exclude CMI < 1.0:		Y													

**Table 22: Cost-Based Direct Care Rate with Single Limit at 120% of Median Cost**

Direct Care															
Type of Rate:		Occupancy Rule:		Rate Analysis											
Cost - Limit		Y		Wtd. Avg. Rate:		All	HB	FS	U	R	S	L	AC NFs	638 NFs	
CMI Data Options:		Exclude Mdcr		Maximum Rate:		\$186.17	\$186.17	\$145.39	\$145.39	\$186.17	\$186.17	\$145.39	\$186.17	\$ 94.67	
				Minimum Rate:		\$ 62.44	\$ 64.49	\$ 62.44	\$ 73.37	\$ 62.44	\$ 62.44	\$ 80.24	\$ 64.49	\$ 94.67	
				Average Cost Coverage:		97.70%	94.29%	98.41%	97.95%	97.61%	99.27%	96.30%	100.00%	100.00%	
Overall CMI Calculation		2020		Facilities Impacted by Max Limit		17	7	10	5	12	7	10	0	0	
Medicaid CMI Source				Facilities Impacted by Min Limit		0	0	0	0	0	0	0	0	0	
Ceiling/Limit/Price Calculations:				Special Limits/Ceilings		Maximum Rate @ CMI 1.0:									
Median		\$ 88.52		AC NFs:		100%		of costs.		\$106.22					
Max. Ceiling/Limit/Price		120% \$ 106.22		638 NFs:		100%		of costs.							
Min. Ceiling		115% NA													
Exclude CMI < 1.0:		Y													



Again these examples show the capabilities that users had to investigate different rate setting parameters and the impact of different settings. The Workgroup was encouraged to use the model and analyze the potential impact of different rate setting options. They were asked to share any recommendations for parameter settings that should be analyzed further. The analysis and findings presented in the remainder of this section focus on those aspects of the reimbursement system that garnered the most discussion.

### Cost Center Ceiling Analysis

Myers and Stauffer prepared an analysis to evaluate the impact of the dual ceiling approach used in the current methodology. This involved running scenarios with rate calculations under the current methodology, with the current methodology using just one ceiling per cost center, and the current methodology with one ceiling adjusted to a budget neutral level. The tables below show the results of this analysis for the Direct Care cost center.

**Table 23: Current Two Ceiling Methodology for Direct Care Cost Center**

Direct Care														
Type of Rate:		Occupancy Rule:		Rate Analysis										
Cost - Ceilings		Y		Wtd. Avg. Rate:		All	HB	FS	U	R	S	L	AC NFs	638 NFs
				Maximum Rate:		\$101.16	\$113.08	\$ 98.68	\$105.18	\$ 99.64	\$ 94.17	\$107.40	\$104.65	\$ 94.67
				Minimum Rate:		\$186.17	\$186.17	\$145.39	\$145.39	\$186.17	\$186.17	\$145.39	\$186.17	\$ 94.67
CMI Data Options:				Average Cost Coverage:		\$ 62.44	\$ 64.49	\$ 62.44	\$ 73.37	\$ 62.44	\$ 62.44	\$ 80.24	\$ 64.49	\$ 94.67
Overall CMI Calculation		Exclude Mdcr		Facilities Impacted by Max Limit		97.99%	95.01%	98.61%	98.20%	97.91%	99.37%	96.75%	100.00%	100.00%
Medicaid CMI Source		2020		Facilities Impacted by Min Limit		14	5	9	4	10	5	9	0	0
						22	7	15	9	13	8	14	0	0
Ceiling/Limit/Price Calculations:				Special Limits/Ceilings				Maximum Rate @ CMI 1.0:						
Median		\$ 88.52												
Max. Ceiling/Limit/Price		125% \$ 110.65		AC NFs: 100% of costs.		\$108.88								
Min. Ceiling		115% \$ 101.80		638 NFs: 100% of costs.										
Exclude CMI < 1.0:		Y												

**Table 24: Using One Ceiling Set at the Current Maximum Ceiling for Direct Care Cost Center**

Direct Care														
Type of Rate:		Occupancy Rule:		Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Limit		Y		Wtd. Avg. Rate:		\$101.49	\$113.82	\$ 98.92	\$105.58	\$ 99.94	\$ 94.29	\$107.91	\$104.65	\$ 94.67
				Maximum Rate:		\$186.17	\$186.17	\$145.39	\$145.39	\$186.17	\$186.17	\$145.39	\$186.17	\$ 94.67
CMI Data Options:				Minimum Rate:		\$ 62.44	\$ 64.49	\$ 62.44	\$ 73.37	\$ 62.44	\$ 62.44	\$ 80.24	\$ 64.49	\$ 94.67
Overall CMI Calculation		Exclude Mdcr		Average Cost Coverage:		98.23%	95.54%	98.78%	98.49%	98.12%	99.47%	97.12%	100.00%	100.00%
Medicaid CMI Source		2020		Facilities Impacted by Max Limit		14	5	9	4	10	5	9	0	0
				Facilities Impacted by Min Limit		0	0	0	0	0	0	0	0	0
Ceiling/Limit/Price Calculations:				Special Limits/Ceilings				Maximum Rate @ CMI 1.0:						
Median		\$ 88.52												
Max. Ceiling/Limit/Price		125% \$ 110.65		AC NFs: 100% of costs.		\$110.65								
Min. Ceiling		115% NA		638 NFs: 100% of costs.										
Exclude CMI < 1.0:		Y												



**Table 25: Using One Ceiling Set at a Budget Neutral Level for Direct Care Cost Center**

Direct Care										
Type of Rate:	Occupancy Rule:	Rate Analysis		All	HB	FS	U	R	S	L
Cost - Limit	Y	Wtd. Avg. Rate:		\$101.06	\$112.82	\$ 98.62	\$105.14	\$ 99.53	\$ 94.15	\$107.23
CMI Data Options:		Maximum Rate:		\$186.17	\$186.17	\$145.39	\$145.39	\$186.17	\$186.17	\$145.39
Overall CMI Calculation		Minimum Rate:		\$ 62.44	\$ 64.49	\$ 62.44	\$ 73.37	\$ 62.44	\$ 62.44	\$ 80.24
Medicaid CMI Source		Average Cost Coverage:		97.92%	94.83%	98.57%	98.19%	97.82%	99.36%	96.64%
Ceiling/Limit/Price Calculations:		Facilities Impacted by Max Limit		15	5	10	4	11	5	10
Median		Facilities Impacted by Min Limit		0	0	0	0	0	0	0
Max. Ceiling/Limit/Price		Special Limits/Ceilings		Maximum Rate @ CMI 1.0:						
Min. Ceiling		AC NFs: 100%		\$107.99						
Exclude CMI < 1.0:		638 NFs: 100%								

The tables show the setting used for each scenario and the statistical analysis generated for each. A few of the key statistics include the weighted average rate, the average cost coverage, and the number of facilities impacted by the ceiling(s). The differences in the outcomes between each scenario are relatively small. For comparison the statistics for all facilities have been copied into Table 16 for each option. A total cost calculation has also been added for each scenario. These were determined by multiplying the estimated Medicaid days by the weighted average rate under each scenario.

**Table 26: Comparison of Direct Care Limit Options**

Direct Care Limit Options Analysis			
Analysis Statistic	Two Ceilings	One Ceiling at 125%	One Ceiling at 122%
Wtd. Avg. Rate:	\$ 101.16	\$ 101.49	\$ 101.06
Maximum Rate:	\$ 186.17	\$ 186.17	\$ 186.17
Minimum Rate:	\$ 62.44	\$ 62.44	\$ 62.44
Average Cost Coverage:	97.99%	98.23%	97.92%
Facilities Impacted by Max Limit	14	14	15
Facilities Impacted by Min Limit	22	0	0
Estimated Medicaid Days	998,827	998,827	998,827
Estimated Cost (Days x Wtd Avg Rate)	\$ 101,041,339.32	\$ 101,370,952.23	\$ 100,941,456.62
Change in Estimated Cost	NA	\$ 329,612.91	\$ (99,882.70)
Percentage Change in Estimated Cost	NA	0.33%	-0.10%

The table shows the overall cost for Direct Care changes very little between the three scenarios relative to the total estimated cost. Using one ceiling with a budget neutral approach required the limit to be set to 122% of the median. This produces the lowest estimated costs at \$100.94M. This isn't exactly budget neutral since the estimated cost under the current two ceiling approach is actually \$101.04M but creating an exactly budget neutral approach would require using something other than a rounded percentage of the median for the ceiling calculation. Still the difference between these two scenarios is less than \$100,000 or about 0.10%. Using one ceiling set at the current maximum ceiling increases the impact of change to around \$330,000 or about 0.33% but is still relatively minimal compared to total estimated costs.

Myers and Stauffer also ran similar cost center ceiling analysis for the General Administrative cost center. This provided information to evaluate the impact of the dual ceiling approach used in the current methodology for General Administrative. As with the Direct Care cost center, we ran scenarios with rate calculations under the current methodology, with the current methodology using just one ceiling per cost center, and the current methodology with one ceiling adjusted to a budget neutral level. The tables below show the results of this analysis for the General Administrative cost center.



**Table 27: Current Two Ceiling Methodology for General Administrative Cost Center**

General Administrative														
Type of Rate:	Occupancy Rule:			Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Ceilings	Y			Wtd. Avg. Rate:		\$ 20.00	\$ 19.12	\$ 20.18	\$ 20.41	\$ 19.84	\$ 19.83	\$ 20.15	\$ 18.77	\$ 33.64
				Maximum Rate:		\$ 33.64	\$ 20.80	\$ 33.64	\$ 20.80	\$ 33.64	\$ 33.64	\$ 20.80	\$ 20.03	\$ 33.64
Other Rate Options:				Minimum Rate:		\$ 11.10	\$ 11.10	\$ 13.97	\$ 14.10	\$ 11.10	\$ 11.10	\$ 14.08	\$ 11.10	\$ 33.64
Include with Non-Direct	N			Average Cost Coverage:		73.97%	78.00%	73.00%	65.00%	77.00%	78.00%	70.00%	75.00%	100.00%
				Facilities Impacted by Max Limit		73	12	61	22	51	45	28	7	0
				Facilities Impacted by Min Limit		76	12	64	23	53	46	30	7	0
Ceiling/Limit/Price Calculations														
Median		\$ 19.08		Special Limits/Ceilings		Maximum Rate:								
Max. Ceiling/Limit/Price	110%	\$ 20.99	AC NFs:	105%	of median.	\$ 20.03	\$ 20.80							
Min. Ceiling	105%	\$ 20.03	638 NFs:	100%	of costs.									
Exclude CMI < 1.0:	Y													
Exclude Chains	Y													

**Table 28: Using One Ceiling Set at the Current Maximum Ceiling for General Administrative Cost Center**

General Administrative												
Type of Rate:	Occupancy Rule:	Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Limit	Y	Wtd. Avg. Rate:		\$ 20.19	\$ 19.43	\$ 20.35	\$ 20.58	\$ 20.05	\$ 20.07	\$ 20.31	\$ 19.54	\$ 33.64
Other Rate Options:		Maximum Rate:		\$ 33.64	\$ 20.99	\$ 33.64	\$ 20.99	\$ 33.64	\$ 33.64	\$ 20.99	\$ 20.99	\$ 33.64
		Minimum Rate:		\$ 11.10	\$ 11.10	\$ 13.97	\$ 14.10	\$ 11.10	\$ 11.10	\$ 14.08	\$ 11.10	\$ 33.64
		Average Cost Coverage:		74.60%	78.00%	74.00%	66.00%	78.00%	79.00%	71.00%	77.00%	100.00%
Include with Non-Direct		Facilities Impacted by Max Limit		73	12	61	22	51	45	28	7	0
		Facilities Impacted by Min Limit		0	0	0	0	0	0	0	0	0
Ceiling/Limit/Price Calculations												
Median		\$ 19.08	Special Limits/Ceilings				Maximum Rate:					
Max. Ceiling/Limit/Price	110%	\$ 20.99	AC NFs:	105%	of median.	\$ 20.03	\$ 20.99					
Min. Ceiling	105%	NA	638 NFs:	100%	of costs.							
Exclude CMI < 1.0:	Y											
Exclude Chains	Y											

**Table 29: Using One Ceiling Set at a Budget Neutral Level for General Administrative Cost Center**

General Administrative														
Type of Rate:		Occupancy Rule:		Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Limit		Y		Wtd. Avg. Rate:		\$ 19.90	\$ 19.18	\$ 20.06	\$ 20.23	\$ 19.78	\$ 19.80	\$ 19.99	\$ 19.23	\$ 33.64
Other Rate Options:				Maximum Rate:		\$ 33.64	\$ 20.61	\$ 33.64	\$ 20.61	\$ 33.64	\$ 33.64	\$ 20.61	\$ 20.61	\$ 33.64
				Minimum Rate:		\$ 11.10	\$ 11.10	\$ 13.97	\$ 14.10	\$ 11.10	\$ 11.10	\$ 14.08	\$ 11.10	\$ 33.64
				Average Cost Coverage:		73.68%	78.00%	73.00%	65.00%	77.00%	78.00%	70.00%	76.00%	100.00%
Include with Non-Direct		N		Facilities Impacted by Max Limit		75	12	63	23	52	45	30	7	0
				Facilities Impacted by Min Limit		0	0	0	0	0	0	0	0	0
Ceiling/Limit/Price Calculations														
Median		\$ 19.08		Special Limits/Ceilings		Maximum Rate:								
Max. Ceiling/Limit/Price		108%	\$ 20.61	AC NFs:	105%	of median.	\$ 20.03	\$ 20.61						
Min. Ceiling		105%	NA	638 NFs:	100%	of costs.								
Exclude CMI < 1.0:		Y												
Exclude Chains		Y												

The tables show the settings used for each scenario and the statistical analysis generated for each scenario used to investigate options for setting the General Administrative cost center limit(s). As with the Direct Care cost center, the differences in the outcomes between each scenario for the General Administrative cost center are relatively small. For comparison the statistics for all facilities have been copied into the following table for each option. A total cost calculation has also been included for each scenario.



**Table 30: Comparison of General Administrative Limit Options**

General Administration Options Analysis			
Analysis Statistic	Two Ceilings	One Ceiling at 125%	One Ceiling at 108%
Wtd. Avg. Rate:	\$ 20.00	\$ 20.19	\$ 19.90
Maximum Rate:	\$ 33.64	\$ 33.64	\$ 33.64
Minimum Rate:	\$ 11.10	\$ 11.10	\$ 11.10
Average Cost Coverage:	73.97%	74.60%	73.68%
Facilities Impacted by Max Limit	73	73	75
Facilities Impacted by Min Limit	76	0	0
Estimated Medicaid Days	998,827	998,827	998,827
Estimated Cost (Days x Wtd Avg Rate)	\$ 19,976,540.00	\$ 20,166,317.13	\$ 19,876,657.30
Change in Estimated Cost	NA	\$ 189,777.13	\$ (99,882.70)
Percentage Change in Estimated Cost	NA	0.95%	-0.50%

Myers and Stauffer ran similar cost center ceiling analysis for the Combined Non-Direct Care cost center. The tables that follow show the results of this analysis.

**Table 31: Current Two Ceiling Methodology for Combined Non-Direct Care Cost Center**

Combined Non-Direct Care														
Type of Rate:		Occupancy Rule:		Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Ceilings		Y		Wtd. Avg. Rate:		\$ 70.26	\$ 74.44	\$ 69.39	\$ 68.77	\$ 70.82	\$ 68.87	\$ 71.50	\$ 71.66	\$ 78.28
				Maximum Rate:		\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 79.28	\$ 78.28
				Minimum Rate:		\$ 43.34	\$ 56.93	\$ 43.34	\$ 52.08	\$ 43.34	\$ 43.34	\$ 52.08	\$ 58.11	\$ 78.28
				Average Cost Coverage:		96.31%	91.00%	97.00%	99.00%	95.00%	97.00%	95.00%	95.00%	99.00%
				Facilities Impacted by Max Limit		24	10	14	2	22	13	11	4	0
				Facilities Impacted by Min Limit		34	14	20	7	27	21	13	4	1
Ceiling/Limit/Price Calculations				Special Limits/Ceilings				Maximum Rate:						
Median		\$	72.74											
Max. Ceiling/Limit/Price	110%	\$	80.01	AC NFs:	105%	of median.	\$	76.38		\$	79.28			
Min. Ceiling	105%	\$	76.38	638 NFs:	100%	of costs.								
Exclude CMI < 1.0:	Y													

**Table 32: Using One Ceiling Set at the Current Maximum Ceiling for Combined Non-Direct Care Cost Center**

Combined Non-Direct Care														
Type of Rate:		Occupancy Rule:		Rate Analysis		All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Limit		Y				Wtd. Avg. Rate:	\$ 70.48	\$ 74.90	\$ 69.56	\$ 68.85	\$ 71.09	\$ 69.08	\$ 71.72	\$ 71.99
				Maximum Rate:	\$ 80.01	\$ 80.01	\$ 80.01	\$ 80.01	\$ 80.01	\$ 80.01	\$ 80.01	\$ 80.01	\$ 80.01	\$ 78.75
				Minimum Rate:	\$ 43.34	\$ 56.93	\$ 43.34	\$ 52.08	\$ 43.34	\$ 43.34	\$ 52.08	\$ 58.11	\$ 78.75	
				Average Cost Coverage:	96.55%	91.00%	98.00%	99.00%	96.00%	98.00%	96.00%	95.00%	100.00%	
				Facilities Impacted by Max Limit	24	10	14	2	22	13	11	4	0	0
				Facilities Impacted by Min Limit	0	0	0	0	0	0	0	0	0	0
Ceiling/Limit/Price Calculations														
Median			\$ 72.74	Special Limits/Ceilings		Maximum Rate:								
Max. Ceiling/Limit/Price		110%	\$ 80.01	AC NFs:	105%	of median.	\$ 80.01							
Min. Ceiling		105%	NA	638 NFs:	100%	of costs.								
Exclude CMI < 1.0:		Y												

Combined Non-Direct Care															
Type of Rate:		Occupancy Rule:		Rate Analysis			All	HB	FS	U	R	S	L	AC NFs	638 NFs
Cost - Limit		Y		Wtd. Avg. Rate:			\$ 70.08	\$ 74.08	\$ 69.25	\$ 68.71	\$ 70.59	\$ 68.71	\$ 71.30	\$ 71.34	\$ 78.56
				Maximum Rate:			\$ 78.56	\$ 78.56	\$ 78.56	\$ 78.56	\$ 78.56	\$ 78.56	\$ 78.56	\$ 78.56	\$ 78.56
				Minimum Rate:			\$ 43.34	\$ 56.93	\$ 43.34	\$ 52.08	\$ 43.34	\$ 43.34	\$ 52.08	\$ 58.11	\$ 78.56
				Average Cost Coverage:			96.12%	91.00%	97.00%	98.00%	95.00%	97.00%	95.00%	94.00%	100.00%
				Facilities Impacted by Max Limit			28	12	16	3	25	17	11	4	1
				Facilities Impacted by Min Limit			0	0	0	0	0	0	0	0	0
Ceiling/Limit/Price Calculations				Special Limits/Ceilings			Maximum Rate:								
Median		\$ 72.74		AC NFs: 105% of median.			\$ 76.38								
Max. Ceiling/Limit/Price		108% \$ 78.56		638 NFs: 100% of costs.			\$ 78.56								
Min. Ceiling		105% NA													
Exclude CMI < 1.0:		Y													



As with the other cost centers, these tables show the settings used for each scenario and the statistical analysis generated for each scenario for setting the Combined Non-Direct cost center limit(s). Once again the differences in the outcomes between each scenario for the Combined Non-Direct cost center are relatively small. The table below summarizes the outcomes for each scenario and includes a total cost calculation for each.

**Table 33: Comparison of Combined Non-Direct Care Limit Options**

Combined Non-Direct Care Options Analysis			
Analysis Statistic	Two Ceilings	One Ceiling at 125%	One Ceiling at 108%
Wtd. Avg. Rate:	\$ 70.26	\$ 70.48	\$ 70.08
Maximum Rate:	\$ 79.28	\$ 80.01	\$ 78.56
Minimum Rate:	\$ 43.34	\$ 43.34	\$ 43.34
Average Cost Coverage:	96.31%	96.55%	96.12%
Facilities Impacted by Max Limit	24	24	28
Facilities Impacted by Min Limit	34	0	0
Estimated Medicaid Days	998,827	998,827	998,827
Estimated Cost (Days x Wtd Avg Rate)	\$ 70,177,585.02	\$ 70,397,326.96	\$ 69,997,796.16
Change in Estimated Cost	NA	\$ 219,741.94	\$ (179,788.86)
Percentage Change in Estimated Cost	NA	0.31%	-0.26%



### Value Based Purchasing Modeling

One of the reimbursement policy areas that was included in the guidelines for this rate review is performance based contracting, often referred to in long term care as value based purchasing (VBP). Myers and Stauffer developed a value based purchasing model within the rate model to explore and evaluate different VBP options. The VBP model was built using readily available data accessible through the CMS 5-Star Rating System. That system includes ratings based on facility performance in three areas; health inspections, staffing, and quality measures.

The VBP model was constructed to incorporate many options that could be adjusted by users. These include the option to use health inspection performance as a qualifying factor to determine a facility's eligibility for VBP payments. This can be done by setting a VBP percentage for each health inspection rating level. There are five rating levels ranging from 1 star to 5 stars with 5 stars representing the highest performance. There is also a rating of zero to account for facilities that do not have enough data in the system yet. The VBP percentage can control what homes qualify for the incentive by applying it as a factor for calculating incentive per diem add-ons. For example, a home with a 1-Star rating for health inspections is not performing well and should probably be excluded from any VBP incentives. By setting the VBP percentage to 0% for a rating of "1" that percentage can be used as a factor to zero out any other incentive the provider may qualify for. Applying the VBP percentage in this manner can help to ensure that the State's reimbursement system and the health inspection process are synchronized. The example below illustrates the use of the VBP percentage to adjust the performance incentives so that the health inspection ratings and VBP incentives correspond.

**Table 34: Using the VBP Percentage to Adjust Incentive Add-ons**

Facility VBP Calculation Using the VBP % for Health Inspections					
Health Inspection Rating	VBP%		Other VBP Incentives		Allowed VBP Incentives
5	100%	X	\$4.00	=	\$4.00
3	50%	X	\$4.00	=	\$2.00
1	0%	X	\$4.00	=	\$0.00

The other primary option that is included in the VBP modeling is the ability to set per diem rates for each level of performance for the Overall 5-Star ratings, as well as the ratings for staffing and quality measures. In each case these rates can be set to a dollar value ranging from \$0.00 to \$10.00. This then determines what per diem each provider qualifies for based on their performance on each 5-Star category. If these rates are set to \$0.00 for all ratings for a 5-Star category then that essentially removes that category from the VBP system. This might be done in the case of a VBP system that uses the Overall 5-Star rating as it would be redundant to have VBP add-on available for staffing and quality measures when those items are already included in the overall rating. This is illustrated by settings included in the table below.



**Table 35: VBP Model Settings Using the Overall 5-Star Rating Only**

VBP Parameters															
Health Inspection			Overall 5-Star Rating			Staffing 5-Star Rating			QM 5-Star Rating			QM Scoring			
Rating	Facilities	VBP %	Rating	Facilities	Rate	Rating	Facilities	Rate	Rating	Facilities	Rate	Tier	Min Score	Facilities	Rate
5	9	100%	5	21	6.00	5	21	0.00	5	25	0.00	1	680	9	0.00
4	25	100%	4	28	3.00	4	36	0.00	4	25	0.00	2	620	21	0.00
3	19	100%	3	18	1.00	3	23	0.00	3	35	0.00	3	560	22	0.00
2	22	100%	2	20	0.00	2	4	0.00	2	9	0.00	4	500	25	0.00
1	21	100%	1	9	0.00	1	12	0.00	1	2	0.00	5	320	22	0.00
0	5	0%	0	5	0.00	0	5	0.00	0	5	0.00	0	0	2	0.00
101			101			101			101			101			
Median is 560, 75th Percentile is 620															
Estimated Fiscal Impact			\$ 1,883,027.00			Average Incentive (Qualifying NFs)			PPD \$ 3.40			Total VBP Payment \$ 28,105			
Percent of Total Expenditures			1.09%			Maximum Incentives			\$ 6.00			\$ 82,590			
Facilities Qualifying for Incentive			67												

A final modeling option included for VBP is the ability to set QM scoring tiers based on the raw scores used for the QM rating. These raw scores can total to as much as 800 points with 100 points available for each of the eight long-stay measures that are included in the 5-Star QM rating. By setting minimum scores for each tier thresholds can be created to determine what criteria is needed to qualify for each tier. As with the other VBP performance measures rates can also be set for each tier to establish the incentive that corresponds to each level. The table below shows a VBP model based entirely on QM scoring tiers. It should be noted that the VBP model is based on the latest available 5-Star ratings and QM scores. These cover the four quarters ending with the fourth quarter of 2019.

**Table 36: VBP Model Settings Using QM Scoring Only**

VBP Parameters															
Health Inspection			Overall 5-Star Rating			Staffing 5-Star Rating			QM 5-Star Rating			QM Scoring			
Rating	Facilities	VBP %	Rating	Facilities	Rate	Rating	Facilities	Rate	Rating	Facilities	Rate	Tier	Min Score	Facilities	Rate
5	9	100%	5	21	0.00	5	21	0.00	5	25	0.00	1	680	9	6.00
4	25	100%	4	28	0.00	4	36	0.00	4	25	0.00	2	620	21	3.00
3	19	100%	3	18	0.00	3	23	0.00	3	35	0.00	3	560	22	1.00
2	22	100%	2	20	0.00	2	4	0.00	2	9	0.00	4	500	25	0.00
1	21	100%	1	9	0.00	1	12	0.00	1	2	0.00	5	320	22	0.00
0	5	0%	0	5	0.00	0	5	0.00	0	5	0.00	0	0	2	0.00
101			101			101			101			101			
Median is 560, 75th Percentile is 620															
Estimated Fiscal Impact			\$ 1,215,905.00			Average Incentive (Qualifying NFs)			PPD \$ 2.61			Total VBP Payment \$ 23,841			
Percent of Total Expenditures			0.71%			Maximum Incentives			\$ 6.00			\$ 80,463			
Facilities Qualifying for Incentive			51												

Statistics are also included in the VBP Parameters table to provide some means for measuring the impact of the modeled settings. These include an estimated fiscal impact that shows what the expected expenditures for the VBP program would be. A percentage of total expenditures is also calculated comparing the VBP fiscal estimate to the total nursing facility program cost estimate. Counts are also included to show how many providers would qualify for incentive payments, as well as how many providers meet the individual performance measure criteria. Referring back to the table above, the



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estimated fiscal impact of the VBP program modeled is \$1,215,905, with 51 providers that qualify for an incentive.

There are many performance measures that could be included in a VBP program for nursing facilities. However, the model Myers and Stauffer developed limited the options to data pulled from the CMS 5-Star rating system. These ratings cover a broad spectrum of provider performance by evaluating health inspections, staffing, and quality measures. Although the VBP model was limited to these three inputs there are still numerous combinations of settings that users could employ to create a VBP system. Adjusting these settings was modeled for the Workgroup, and Workgroup members were asked to investigate different options and provide input on their recommendations. That input was considered and influence the final VBP recommendations included in the Recommendation section of this report.



### Extraordinary Care Analysis

The Extraordinary Care Additional Payment (EC) program is another aspect of the South Dakota nursing facility reimbursement system that the Workgroup cited as a concern. One Workgroup member stated that the EC payment process is awkward and really doesn't create an incentive because payments are offset back against cost. LTSS staff also shared that the EC program requires a great deal of administrative time to review documentation submitted by providers to support the request for EC payments. For these reasons Myers and Stauffer worked with DHS LTSS staff extensively to investigate options for automating and simplifying the extraordinary care additional payment process.

We started by reviewing expenditures for the EC program. Program expenditures can be divided into several different categories including wound care, ventilator services, traumatic brain injury (TBI), extreme behavior, and chronic complex needs. The total expenditures for EC are usually between \$4 and \$5 million per year with the bulk of those costs tied to extreme behavior and traumatic brain injury. The chart below shows the breakdown of EC expenditures for 2019.

**Table 37: Extraordinary Care Expenditures by Category**

Category	Residents	Expenditures
279-Wound Vacuum	2	4,606
Not Categorized	4	8,966
412-Ventilator	32	230,514
559-Other Skilled Nursing (Chronic Complex Needs)	221	670,628
118-Traumatic Brain Injury	191	1,607,737
919-Extreme Behavior	790	1,993,694
Totals	1,240	4,516,144

Through discussions with LTSS staff we were also able to narrow the focus of our analysis to a few service areas that create the largest administrative burden, and also eliminate other services from the analysis that are already relatively automated. The services that were eliminated from review included ventilator and traumatic brain injury services. To qualify for EC payments under these two service areas, the resident must meet strict criteria and the payment calculations are already well defined. Chronic complex needs was a service area that LTSS staff noted requires extensive documentation review but due to unique nature of most of these cases it was decided that administrative burden is unavoidable. That left wound care and extreme behavior as the two EC service areas for further review.

Myers and Stauffer attempted to develop an alternative method for identifying individuals that would qualify for EC payments for extreme behaviors. We used Cognitive Performance Scale (CPS) scores and BIMS scores to identify individuals that the EC payments might be targeted to. We developed a model to calculate reimbursement amounts for each facility using a methodology based on the CPS and BIMS data. Unfortunately we found no reliable way to mimic past reimbursement levels.

Despite the failure to find a way to use the CPS/BIMS data to identify EC extreme behavior candidates, we did determine that a primary need for these individuals is a private room. Because these individual's



behavior often interferes with their own quality of life or distracts from the quality of life for other residents, they are regularly placed in private rooms. The need for a private room is often the primary criteria used to determine if the individual qualifies for EC payments for extreme behaviors. This common trait provided a solution to identifying individuals that might be designated as eligible for EC payments. Although this need is usually documented through the EC application process it could also be incorporated into the state specific section of the MDS assessment (Section S). This section allows states to capture data that is relevant to managing the nursing home program but is not available through the CMS data set.

South Dakota has submitted an amendment request to CMS asking that an additional question be added to Section S for all South Dakota assessments. The additional question will ask the reviewer to indicate whether or not a private room is required to manage the behaviors of the individual. An edit will be added to the South Dakota MDS data review system to identify individuals that require private rooms. A private room rate add-on will be calculated from capital costs to determine what the reimbursement for each individual should be. This process will be based on other existing rate calculations eliminating the need for facilities to submit documentation of the EC costs.

The other EC area that was identified as a potential opportunity to improve the EC process is wound vacuum care. Traditionally this has been reimbursed based on invoice documentation for wound vacuum care services costs for individuals that receive a doctor's authorization for this service. LTSS staff have determined that a set rate can be applied statewide for wound vacuum care. This will eliminate the need to collect invoices and other documentation of the cost of this service. Residents will still need authorization from a doctor to identify the need for wound vacuum treatment.



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### Cost Reporting

During the course of the rate review process it became apparent that some useful data elements were not included in the current cost report. For the rate review these data elements were mostly collected through the provider survey. However, the experience created the sense that additions should be made to the Medicaid cost report to capture at least some of this information on an ongoing basis.

The COVID-19 pandemic experience has also created a need for additional cost reporting information. During this period nursing homes have incurred extraordinary expenses for personal protective equipment, nursing supplies, cleaning supplies, and other costs related to increased efforts to enhance infection control. At the same time many nursing homes have experienced significant decrease in resident days. These two factors will combine to distort per diem costs calculated from the Medicaid cost reports. As these per diem costs are the traditional basis for Medicaid rates, the implications are that future Medicaid rates could fail to be representative of future expenditures. While this failure is an important consideration for future rate setting efforts it is also important to note that the cost experience during 2020 can provide valuable information about the additional costs incurred due to the pandemic. To adequately address the concerns about distorted cost data and the desire to evaluate pandemic related cost increases requires additional cost reporting information that has not traditionally been collected.

There are several cost reporting adjustments that can be made to address the additional data the workgroup identified as valuable and the pandemic related cost reporting needs and challenges.



# Recommendations

After several months of analyzing the South Dakota Medicaid Nursing Home rate setting methodology and gathering input from industry leaders, state administrators, and other stakeholders there are several aspects of the reimbursement system that could clearly be improved or at least simplified. These include adjusting the inflation factor to an industry specific index, eliminating the dual ceiling methodology, incorporating a value based payment system, creating incentives for maintaining and rehabbing property through a fair rental or rebasing approach, and automating more of the extraordinary care additional payment provisions.

However, it should also be noted that the base reimbursement system includes many aspects that are aligned with best practices for Medicaid nursing facility reimbursement. The current system recognizes provider specific cost experience but imposes limits to avoid excessive payments. It includes provisions to support access to care in all areas of the state and to enable providers to serve residents with extraordinary care issues. The system also includes the most sensitive acuity adjustment process available. All of these characteristics are strengths that should be preserved in future iterations of the rate setting methodology.

What was abundantly clear from the start of this project is that the biggest challenge facing the nursing home program is funding. That was certainly no surprise. It's the same challenge that most state Medicaid nursing home programs face. Unfortunately, the circumstances surrounding the coronavirus pandemic that evolved during the spring of 2020 have only served to compound the financial challenges facing nursing facilities and Medicaid reimbursement. Fortunately, assistance for this new challenge has been provided through federal funding programs. This current challenge and the ongoing funding challenges will continue, but the focus of this review was the evaluation and design of the rate methodologies. The detailed recommendations that follow address the aspects of the reimbursement system that we identified that could clearly be improved or simplified.

## Adopting an Industry Specific Inflation Index

The Global Insight Skilled Nursing Facility Market Basket Index is the nation's premier index for adjusting nursing facility costs.

## Eliminating the Dual Ceiling Methodology

The dual ceiling approach does not create value for providers or the Department and should be simplified to a single ceiling methodology.



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### Incorporating Value Based Purchasing

Adding a value based purchasing component to the reimbursement system will ensure that payments better align with quality performance and encourage providers to strive for better outcomes.

### Creating Property Incentives

Adopting a fair rental value system or adding provisions for rebasing property costs will better incentivize providers to maintain and rehabilitate the building they operate in.

### Automating Extraordinary Care Payments

Automating more of the extraordinary care payment provisions available to providers will make this aspect of the rate methodology more consistent and less administratively burdensome for providers and state administrators.



### Recommendations Summary

The following table provides a brief description of each of the recommendations presented. It also lists the overall fiscal impact, the per diem impact, and provides notes to further clarify what is being recommended.

**Table 38: Final Recommendations Summary**

South Dakota Nursing Facility Reimbursement Review				
Final Recommendations Summary				
Recommendation	Description	Fiscal Impact	Avg. PPD	Notes
Total Fiscal Impact to Rebase NF Rates Using 2018 Costs	The nursing facility rates were calculated for FY 2021 using fiscal year 2018 cost data and the existing nursing facility reimbursement methodology and rate setting parameters.	\$178,095,211	\$ 170.24	Comparing this fiscal estimate to the FY 2021 budget provides an estimated fiscal impact of the immediate cost of rebasing rates. This is also the base scenario that all of the following recommendations are measured against to determine fiscal impact.
Use the GI NF Market Basket Rather Than CPI	The rate of medical inflation is typically higher than many consumer goods and services. The Global Insight Skilled Nursing Facility Market Basket Index (GI Index) is a widely accepted inflationary index utilized by CMS and many states to adjust nursing facility costs for rate setting purposes. The existing nursing facility parameters were held constant under a FY 2021 rate calculation scenario using 2018 costs, except that inflation calculations were made using the GI Index rather than the CPI.	\$ 328,590	\$ 0.32	The fiscal impact shows the estimated cost to switch from the CPI to the GI Index under the base scenario.
Eliminate the Dual Ceiling Methodology	Analysis showed that the dual ceiling approach really has a minimal impact to the Medicaid rates. The intent of the dual ceiling approach is also unclear. This scenario calculates the impact of removing the minimum ceilings currently used in the rate methodology in favor of using a single ceiling for all cost centers set at the current maximum ceiling threshold. This would simplify the rate calculation process and eliminate a part of the methodology that has no clear purpose.	\$ 63,348	\$ 0.06	The fiscal impact shows the estimated cost of removing the minimum ceilings for all applicable cost centers.



**Table 39: Final Recommendations Summary Continued**

South Dakota Nursing Facility Reimbursement Review				
Final Recommendations Summary				
Implement a Value Based Purchasing Add-on	Value based purchasing (VBP) or pay for performance (P4P) incentives are a very common component of today's reimbursement methodologies. VBP provisions ensure that there is some alignment between quality of care and reimbursement levels. This scenario represents one simple approach to a NF VBP program that utilizes data compiled through the CMS Nursing Home Compare system. Specifically, the modeled VBP parameters utilize health survey performance rating to establish minimum qualifying criteria. Per diem add-ons are then determined for each qualifying provider using Five Star rating for staffing and quality measures.	\$ 1,734,423	\$ 1.66	The fiscal impact shows the cost of implementing an approximately 1% VBP program, i.e. VBP payments are approximately equal to 1% of total estimated NF payments under the base scenario. Under the modeled scenario facilities would have to have a 3-star or better rating on health inspections. There are 52 facilities that meet that criteria. Facilities would earn separate per diem add-ons for staffing and quality measures scoring with \$5 awarded for a 5-star rating on either, \$3 for a 4-star rating, and \$1 for a 3-star rating. The average incentive add-on for qualifying facilities would be \$4.13, and the maximum add-on would be \$10.00. This scenario could also be held budget neutral by using a withholding provision.
Implement a Fair Rental Value System	This provision would create incentives for providers to renew their facilities in order to increase their reimbursement. For the scenario presented a Fair Rental Value (FRV) model was used with a new bed value of \$80,000. That value was depreciated at a rate of 1.25% per year based on the age of each facility to a maximum of 48 years or 60%, resulting in a minimum bed value of \$32,000. The age of each facility was based on data obtained through the Department of Social Services. A rental rate of 9.25% was applied to the total calculated value of each facility. The annual fair rental value was converted to a per diem by dividing by total resident days.	\$ 303,861.00	\$ 0.29	The fiscal impact shown represents the estimated first year cost of implementing the modeled FRV methodology over the current property reimbursement. Estimating the cost of future improvements is much more difficult but it appears that for every \$13M in qualifying renovations that facilities make, property reimbursement would increase by about \$200,000 and the average facility age would decrease by about 1 year. The current average facility age as reported by DSS is 42.7 years.
Automate Extraordinary Care Additional Pay Calculations	This scenario involves implementing methods to standardize the calculation of additional per diem payments for extraordinary care. This would be very practical for extraordinary care payments tied to wound vac treatments. It is also applicable to payments made for individuals with behavioral issues.	\$ -	\$ -	This scenario would have minimal or no impact on nursing facility payments, but would reduce the administrative burden for facilities and the state.



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# Appendices

## List of Appendices

- A. SB 147
- B. Workgroup Information
  - i. Member List
  - ii. Meeting Record Reference
- C. Provider Survey
- D. Rate Model
- E. FRV Models
- F. BIMs/CPS Information
- G. Medicaid Cost Report



## Appendix A: Senate Bill 147

### SB 147 CONSENSUS FRAMEWORK 7/20/17

#### PREAMBLE

The community-based service providers and the departments of human and social services are partners in the mission to deliver services to improve the health and well-being of many of the state's most vulnerable citizens. We share many common goals and work collaboratively toward the achievement of these goals. The departments are advocates for the recipients of services and their families as well as for the community-based service providers. The departments are also responsible for regulating and the distribution of available funding to community-based service providers. Community-based service providers deliver a wide range of health, human and social services to the state's most vulnerable populations in partnership with the state and also serve as advocates with the departments and policymakers to improve access to and availability of services. While the departments and community-based service providers may have differing perspectives on regulatory and funding responsibilities on occasion, it is in the public interest that all involved parties respect perspectives and collectively work toward a consensus resolution.

#### PURPOSE AND SCOPE

The purpose and scope is established in Senate Bill 147 as set forth in the following bill sections.

Section 1: The Department of Social Services and the Department of Human Services shall jointly establish a rate setting methodology for services delivered by community-based health and human services providers. Each category of service shall undergo a comprehensive rate modeling analysis at least every five years. The departments may elect to conduct the analysis earlier or on a more frequent basis if warranted by cost report information or other market conditions. Any new service model shall undergo comprehensive rate modeling analysis prior to implementation.

Section 2: Rate modeling analysis shall include a review of current cost report data, specific service delivery and staffing requirements, training and fidelity standards associated with related service models, current market factors, and current and impending state and federal policies that may impact the cost of service delivery. Any information gathered will be public record.

Section 3: Rate modeling analysis shall be an inclusive work group process including providers representing each service category under review.

Section 4: Rate determination resulting from rate modeling analysis utilizing historical cost report information shall be adjusted in a manner to be applied in a prospective fashion subject to federal requirements.

Section 5: The department shall report any rate variance to the Governor and to the Legislature on an annual basis in conjunction with annual budget hearings.



Section 6: This applies to all state funded services, including federal funding, Medicaid and block grant fund sources, state general funds, and other funds allocated by the Department of Social Services or the Department of Human Services, that are provided by the following types of community-based providers:

1. Nursing facilities;
2. Assisted living facilities;
3. In-home service providers;
4. Group care providers;
5. Psychiatric residential treatment facilities;
6. Substance abuse disorder treatment and prevention providers;
7. Community mental health centers;
8. Intermediate care facilities for co-occurring intellectual and developmental disabilities;
9. Community support providers; and
10. Other types of providers deemed appropriate for inclusion by either the secretary of the Department of Social Services or the secretary of the Department of Human Services.

The legislative scope does not include formulating recommendations on the adequacy of current funding levels or on departmental budget requests. The intent of community-based service providers in drafting of SB147 was to build on the rate setting and rate modeling processes that have been utilized by the departments.

#### Clarification of Terminology

The terminology of rate setting methodology and rate modeling analysis are both used in the enacting legislation. They are not interchangeable. The terminology is clarified as follows:

- Rate setting methodology: refers to the overall method or process of establishing service rates. There will be common principles applied across rate setting methodologies i.e. allowable cost components, consideration of administrative costs. The methodologies may vary across categories of services and some may take into consideration the acuity of the recipient.
- Rate modeling analysis: refers to comparing a rate setting methodology against service delivery expectations and then assessing costs of the various components of that methodology. The results of the rate modeling analysis are referred to as the analyzed rate. The analyzed rate can then be compared to a current reimbursement rate and/or to historical costs. The analyzed rate is a system-wide representation of a service, not an individual provider representation. The rate modeling analysis is not intended to prescribe individual provider operations. However, an individual provider may adjust their operations to better align with the analyzed rate.

#### **OUTCOMES**

- Schedule and process that ensures a review of rate modeling analysis at least every 5 years by an inclusive work group. The schedule will reflect the year that the rate analysis is finished. The number and complexity of services within some provider types will warrant that the process of analysis may span multiple years.
- Annual summary of variances between cost report data, modeled rates prospectively adjusted i.e. an inflation factor and current reimbursement rates for all categories of services. An example of a possible format for presenting the summary of the variances is provided in Attachment 1.



- Provider support of budget recommendations that are a result of rate modeling analysis.
- Greater understanding of overall reimbursement models and methodologies.
- Alignment of reimbursement rates to service delivery models within existing resources.

### **STRUCTURE AND PROCESS**

A steering committee that is comprised of high level leadership from the departments and the community-based service providers will facilitate the rate modeling analysis.

The departments will determine their respective representation. The community-based members will be membership association leaders or provider executives.

It is incumbent upon the members of the steering committee to develop a process for rate modeling analysis that is in the greater interest of all designated human and social services providers.

The steering committee should include high level leadership identified by the departments and be representative of the provider types identified in Section 6. The size of the steering committee should promote interactive dialogue and support consensus decision-making.

There is no specific funding allocated to support the work related to the rate modeling analysis. Participants are responsible for their own travel and meeting costs.

It is recognized that a schedule will need to be established for the rate modeling analysis as the departments do not have the staff resources to simultaneously support the analysis for all rates.

### **Steering Committee Responsibilities**

- Determine frequency of meetings
- Establish the criteria for prioritizing category of providers and/or individual rates within a category for rate modeling analysis
- Establish the schedule for rate modeling analysis
- Determine the common principles/parameters that will apply to the rate setting methodology across all sectors
- Provider representatives will facilitate the timely and accurate submission of cost reports and additional information as requested
- Review cost report and rate comparison data across all sectors
- Determine the format for the report on variances between costs and rates
- Determine the category or topic specific work groups
- Review the results/findings from category or topic work groups
- Establish a mechanism for communicating committee actions with provider groups, individual provider organizations and legislators



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### Understandings

It is important that the community-based service providers and departments have a shared understanding of the parameters of this work and the potential implications of the findings and results of the rate comparison and rate modeling analysis. The understandings are as follows:

- There may be a need to review and consolidate or eliminate other collaborative activities that compete for department and provider time and resources.
- Information gathered relative to implementation of SB147 will be public record pursuant to Section 2.
- A rate setting methodology that is consistent with service delivery expectations and requirements is necessary to establish the extent to which services are or are not fully funded.
- The rate modeling analysis may identify rates that are “too low” as well as rates that are “too high”. This could result in changes – both positive and negative – to service rates and level of reimbursement to providers.

Although the legislative scope does not include increasing or re-allocating existing resources, it is conceivable that re-allocation of resources could be a consequence of this process. Community-based service providers support the departments’ prior use of a hold-harmless phase-in approach to reductions in rates or levels of reimburse. The community-based provider types represented in the steering committee will support department budget recommendations that are a result of the rate setting analysis.

### “Parking Lot” Topics/Issues

It is likely that topics/issues will arise during discussions that are outside of the legislative scope of the rate setting methodology project. A list of these topics will be collected on a “parking lot” list but will not be the focus of meetings or discussions relative to this project.

These are just examples of what might show up on a parking lot list:

- How to achieve full funding of existing services
- Prioritization of budget resources – new/expanded services; growth in eligibles; funding of rate methodology to avoid “passing on” structural deficit
- Should independent living centers and community living homes be added to the provider types pursuant to Section 6, item 10



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## Appendix B: Workgroup Information

The following is a list of workgroup members and a record of each meeting.

### Member List

Mark Burkett, CEO, Avera Platte Health Care  
Rhonda Burris, Program Specialist, Long Term Services and Supports, SD Department of Human Services  
Marty Davis, Divisional Vice President of Operations, EmpRes Healthcare Management  
Mark Deak, Executive Director, SDHCA  
Loren Diekman, CEO/President, Jenkins Living Center  
Greg Evans, Audit Manager, Budget and Finance, SD Department of Human Services  
Dave Halferty, Senior Manager, Myers and Stauffer  
Denise Houlette, Director, Budget and Finance, SD Department of Human Services  
Gil Johnson, VP Business Development, SDAHO  
Kim Kouri, Manager Cost Reporting, Good Samaritan Society  
Christine Lewis, Manager, Myers and Stauffer  
Mark Lyons, Shareholder, Casey Peterson Assoc.  
Tom Martinec, Deputy Secretary, SD Department of Human Services  
Jodie Mitchell, Finance Manager/Community Controller, Rapid City Regional  
Jesse Naze, CFO, Seven Sisters Living Center  
Connie Ortega, VP Operations, Western Division Legacy Healthcare  
Nate Ovenden, Lead Reimbursement Advisor, Good Samaritan Society  
Amy Perry, Partner, Myers and Stauffer  
Shawnie Rechtenbaugh, Cabinet Secretary, SD Department of Human Services  
Daryl Reinicke, CEO, Westhills Village  
Sakura Rohleder, Fiscal and Program Analyst, SD Legislative Research Council  
Jeff Steggerda, Consultant, Brighton Consulting Group  
Tom Snyder, Administrator, Avera Mother Joseph Retirement Community  
Yvette Thomas, Director, Long Term Services and Supports, SD Department of Human Services  
Lara Williams, Budget Analyst, SD Bureau of Finance and Management

Minutes from the workgroup meetings are available on the DHS website.



## Appendix C: Provider Survey

### South Dakota Nursing Facility Rate Review Provider Survey

This survey is being conducted by DHS to gather additional information about costs reported on the Medicaid nursing facility cost reports. The information gathered will be used by the Department and the stakeholder workgroup tasked with completing a review of the nursing facility rate setting methodology. Your assistance with this project is appreciated. Please complete the yellow shaded cells. Leave cells blank if they are not applicable to your facility. Some responses must be selected from the available drop-down menu. We recommend reviewing the entire survey before you begin. **Submit the survey to [SDSurveys@mslc.com](mailto:SDSurveys@mslc.com) by December 23, 2019.**

#### I. General Information

1. Medical Vendor Number	
2. Facility Name	
3. Address	
4. Zip Code	
5. Telephone	
6. Accounting Periods Covered by this Report	2017 TO
	2018 TO

#### II. Information Technology Costs

DHS is seeking additional information related to electronic medical records and telehealth costs. For each of these, please report the following:

A. Report your one-time IT system hardware costs, the initial purchase price of all hardware for the last two years for EMR and Telehealth separately.	2017	EMR Costs	Telehealth Costs
	2018		
B. Report your annual software lease cost per year over the last two years for EMR and Telehealth separately.	2017	EMR Costs	Telehealth Costs
	2018		
C. Please indicate whether the 2018 software cost for each area (EMR and Telehealth) is ongoing or not.		Ongoing EMR Costs?	Ongoing Telehealth Costs?
D. Report IT system training costs per year over the last two years for EMR and Telehealth separately. This should include initial and on-going costs.	2017	EMR Costs	Telehealth Costs
	2018		

#### III. Capital Lease Costs

DHS is seeking additional information about building lease costs.

A. Do you lease your building? If no, please skip to section IV.	Lease Y/N?
B. Is your lease with a related party?	Related Party Y/N?
C. If you lease your building what are the annual leases costs for the last two years?	Building Lease Cost
	2017
	2018



## Appendix C: Provider Survey

Medicaid Nursing Home Rate Methodology Review  
Draft 1 - July 17, 2020

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D.	Are the building lease costs reported on line F-6, Rent facility & Grounds, of the cost report?		Reported on F-6 Y/N?	<input type="text"/>
E.	Are other expenses also reported on line F-6, Rent Facility & Grounds, of the cost report?		Other costs on F-6 Y/N?	<input type="text"/>
D.	If you lease your building, who is responsible for capital improvements?		Responsible Party	<input type="text"/>
E.	If you are a lessee responsible for capital improvements, what capital improvement costs have you incurred over the last two years?	2017	Improvement Costs	<input type="text"/>
		2018		<input type="text"/>

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**IV. Medical Director Costs**  
DHS seeks additional information about medical director costs.

A.	If your Medical Director is a staff member, what are the wages/salaries, taxes and benefits costs associated with the Medical Director at your facility over the last two years?	2017	Med Director Salary Costs	<input type="text"/>
		2018		<input type="text"/>

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B.	If your Medical Director is contracted, what is your annual Medical Director fee over the last two years?	2017	Med Director Fees	<input type="text"/>
		2018		<input type="text"/>
C.	What are your other annual costs associated with the Medical Director or Physician Services (e.g. Continuing Education) over the last two years?	2017	Other Med Director Costs	<input type="text"/>
		2018		<input type="text"/>
D.	What are your annual costs for other Physician Services (including telemedicine) over the last two years?	2017	Other Physician Costs	<input type="text"/>
		2018		<input type="text"/>



### Appendix D: Case Mix Rate Model

The following presents the rate model used to analyze changes to the rate methodology and the impact it would have on various types of facilities. Everything that is “green” can be adjusted by either selecting from a drop-down menu or entering a number.

SD Case Mix Rate Model v1.9 for SDDHS, Parameters and Analysis

1

**South Dakota Case Mix Rate Model**  
Date Prepared: 2/26/2020  
Version: 1.9

**DRAFT - Subject To Change - Not for General Distribution**  
This model was developed by Myers and Stauffer LC for the South Dakota Department of Human Services. It is a working model and subject to change. It is intended for use by the Department and the workgroup they have assembled.

**Parameters and Analysis**

**General**

Cost Report Data for Fiscal Years Ending In: 2018

Rate Analysis Groupings:  
HB/FS: Hospital Based (shared costs with hospital) vs. Free Standing Facilities  
U/R: Urban (within OMB defined CBSA) vs. Rural  
S/L: Small vs. Large Facilities      Small Facilities are < or = 60 beds

Inflation Options:  
Index: GPI      Through Date: 12/31/20

Analysis Group:  
Count: 

All	HB	FS	U	R	S	L	AC NFs	638 NFs
106	19	87	28	78	67	39	9	1

**Direct Care**

Type of Rate: Cost - Ceilings  
Occupancy Rule: Y  
CMI Data Options:  
Overall CMI Calculation  
Medicaid CMI Source: Exclude Mdcr  
2018  
Ceiling/Limit/Price Calculations:  
Median: \$ 86.51  
Max. Ceiling/Limit/Price: 125% \$ 108.14  
Min. Ceiling: 115% \$ 99.49  
Exclude CMI < 1.0: Y

Rate Analysis:  
Wtd. Avg. Rate:  
Maximum Rate:  
Minimum Rate:  
Average Cost Coverage:  
Facilities Impacted by Max Limit  
Facilities Impacted by Min Limit  
Special Limits/Ceilings:  
AC NFs: 100% of costs.  
638 NFs: 100% of costs.  
Maximum Rate @ CMI 1.0: \$ 106.41

All	HB	FS	U	R	S	L	AC NFs	638 NFs
\$ 98.94	\$ 109.50	\$ 96.87	\$ 103.72	\$ 97.10	\$ 92.49	\$ 104.54	\$ 98.97	\$ 86.80
\$ 165.57	\$ 165.57	\$ 164.94	\$ 151.10	\$ 165.57	\$ 165.57	\$ 151.10	\$ 165.57	\$ 86.80
\$ 54.32	\$ 66.58	\$ 54.32	\$ 70.78	\$ 54.32	\$ 54.32	\$ 70.78	\$ 54.32	\$ 86.80
98.06%	95.00%	99.00%	98.00%	98.00%	99.00%	97.00%	100.00%	100.00%
14	5	9	4	10	5	9	0	0
24	7	17	10	14	8	16	0	0

**General Administrative**

Type of Rate: Cost - Ceilings  
Occupancy Rule: Y  
Other Rate Options:  
Include with Non-Direct: N  
Ceiling/Limit/Price Calculations:  
Median: \$ 18.65  
Max. Ceiling/Limit/Price: 110% \$ 20.52  
Min. Ceiling: 105% \$ 19.58  
Exclude CMI < 1.0: Y  
Exclude Chains: Y

Rate Analysis:  
Wtd. Avg. Rate:  
Maximum Rate:  
Minimum Rate:  
Average Cost Coverage:  
Facilities Impacted by Max Limit  
Facilities Impacted by Min Limit  
Special Limits/Ceilings:  
AC NFs: 105% of median. \$ 19.58  
638 NFs: 100% of costs.  
Maximum Rate: \$ 20.33

All	HB	FS	U	R	S	L	AC NFs	638 NFs
\$ 19.57	\$ 18.69	\$ 19.74	\$ 19.93	\$ 19.43	\$ 19.38	\$ 19.73	\$ 18.35	\$ 32.88
\$ 32.88	\$ 20.33	\$ 32.88	\$ 20.33	\$ 32.88	\$ 32.88	\$ 20.33	\$ 19.58	\$ 32.88
\$ 10.85	\$ 10.85	\$ 13.66	\$ 13.78	\$ 10.85	\$ 10.85	\$ 13.76	\$ 10.85	\$ 32.88
73.48%	78.00%	73.00%	65.00%	77.00%	78.00%	69.00%	75.00%	100.00%
77	12	65	23	54	46	31	7	0
80	12	68	24	56	47	33	7	0



## Appendix D: Rate Model

SD Case Mix Rate Model v1.9 for SDDHS, Parameters and Analysis

2

**South Dakota Case Mix Rate Model**  
Date Prepared: 2/26/2020  
Version: 1.9

**DRAFT - Subject To Change - Not for General Distribution**  
This model was developed by Myers and Stauffer LC for the South Dakota Department of Human Services. It is a working model and subject to change. It is intended for use by the Department and the workgroup they have assembled.

**Parameters and Analysis**

**Combined Non-Direct Care**

Type of Rate:  
☒ Cost - Ceiling

Occupancy Rule:  
☒ Y

Rate Analysis  
Wtd. Avg. Rate:  
Maximum Rate:  
Minimum Rate:  
Average Cost Coverage:  
Facilities Impacted by Max Limit  
Facilities Impacted by Min Limit

All	HB	FS	U	R	S	L	AC NFs	638 NFs
\$ 68.00	\$ 72.62	\$ 67.09	\$ 66.45	\$ 68.60	\$ 67.32	\$ 68.59	\$ 69.93	\$ 76.45
\$ 77.25	\$ 77.25	\$ 77.25	\$ 77.25	\$ 77.25	\$ 77.25	\$ 77.25	\$ 77.25	\$ 76.45
\$ 41.41	\$ 55.64	\$ 41.41	\$ 50.91	\$ 41.41	\$ 42.35	\$ 41.41	\$ 56.80	\$ 76.45
96.41%	91.00%	97.00%	99.00%	96.00%	97.00%	96.00%	95.00%	99.00%
24	10	14	2	22	13	11	4	0
37	14	23	7	30	24	13	4	1

Ceiling/Limit/Price Calculations  
Median  
Max. Ceiling/Limit/Price  
Min. Ceiling  
Exclude CMI < 1.0:

	\$ 70.87
110%	\$ 77.96
105%	\$ 74.41
Y	

Special Limits/Ceilings  
AC NFs: 105% of median.  
638 NFs: 100% of costs.

Maximum Rate:  
\$ 77.25

**Capital**

Type of Rate:  
☒ Current

Rate Analysis  
Wtd. Avg. Rate:  
Maximum Rate:  
Minimum Rate:  
Average Cost Coverage:  
Facilities Impacted by Limit

All	HB	FS	U	R	S	L	AC NFs	638 NFs
\$ 10.88	\$ 8.31	\$ 11.38	\$ 12.26	\$ 10.34	\$ 8.52	\$ 12.92	\$ 8.98	\$ 3.91
\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 17.62	\$ 3.91
\$ 0.54	\$ 1.29	\$ 0.54	\$ 0.93	\$ 0.54	\$ 0.54	\$ 3.50	\$ 1.29	\$ 3.91
93.56%	95.00%	93.00%	92.00%	94.00%	97.00%	90.00%	90.00%	100.00%
19	3	16	7	12	7	12	2	0

Ceiling/Limit/Price Calculations  
Median  
Max. Ceiling/Limit  
Min. Ceiling

	\$ 11.05
100%	\$ 17.62
	NA

Special Limits/Ceilings  
AC NFs: 105% of median.  
638 NFs: 100% of costs.

Maximum Rate:  
\$ 17.62

**Overall Analysis**

Estimated Fiscal Impact  
Wtd. Avg. Rate  
Medicaid Days  
Estimated Cost  
Estimated VBP Payments  
Total Wtd. Avg. Rate

	\$ 170.24
	1,046,134
	\$ 178,095,210.65
	\$ 1,887,863.00
	\$ 172.05

Rate Analysis  
Wtd. Avg. Rate:  
Maximum Rate:  
Minimum Rate:  
Average Cost Coverage:  
Facilities Impacted by Increase Limit:

All	HB	FS	U	R	S	L	AC NFs	638 NFs
\$ 170.24	\$ 184.25	\$ 167.49	\$ 171.41	\$ 169.79	\$ 166.05	\$ 173.87	\$ 188.63	\$ 200.04
\$ 225.37	\$ 225.37	\$ 210.99	\$ 210.99	\$ 225.37	\$ 225.37	\$ 201.81	\$ 225.37	\$ 200.04
\$ 127.27	\$ 138.48	\$ 127.27	\$ 127.27	\$ 129.42	\$ 127.27	\$ 138.20	\$ 137.43	\$ 200.04
84.98%	83.00%	85.00%	84.00%	85.00%	88.00%	82.00%	92.00%	102.00%
94	15	79	26	68	56	38	3	0

Impose Increase Limit: ☒ Y  
Reg NF Increase Limit %: ☒ 8%  
AC NF Increase Limit %: ☒ 10%  
638 NF Increase Limit %: ☒ 10%



## Appendix D: Rate Model

Medicaid Nursing Home Rate Methodology Review  
Draft 1 - July 17, 2020

SD Case Mix Rate Model v1.9 for SDDHS Value Based Purchasing

### South Dakota Case Mix Rate Model

Date Prepared: 2/26/2020

Version: 1.9

**DRAFT - Subject To Change - Not for General Distribution**

This model was developed by Myers and Stauffer LC for the South Dakota Department of Human Services. It is a working model and subject to change. It is intended for use by the Department and the workgroup they have assembled.

### Parameters and Analysis

V Value Based Payments															
Health Inspection			Overall 5-Star Rating			Staffing 5-Star Rating			QM 5-Star Rating			QM Scoring			
Rating	Facilities	VBP %	Rating	Facilities	Rate	Rating	Facilities	Rate	Rating	Facilities	Rate	Tier	Min Score	Facilities	Rate
5	9	100%	5	21	0.00	5	21	6.00	5	26	0.00	1	680	9	6.00
4	25	100%	4	28	0.00	4	37	3.00	4	25	0.00	2	620	22	3.00
3	20	100%	3	19	0.00	3	23	1.00	3	35	0.00	3	560	23	1.00
2	22	0%	2	21	0.00	2	4	0.00	2	10	0.00	4	500	25	0.00
1	22	0%	1	9	0.00	1	13	0.00	1	2	0.00	5	320	23	0.00
0	8	0%	0	8	0.00	0	8	0.00	0	8	0.00	0	0	4	0.00
106			106			106			106			106			
Median is 560, 75th Percentile is 620															
Estimated Fiscal Impact		\$ 1,887,863.00				Average Incentive (Qualifying NFs)		PPD \$ 4.52		Total VBP Payment \$ 36,305					
Percent of Total Expenditures		1.05%				Maximum Incentives		\$ 12.00		\$ 112,116					
Facilities Qualifying for Incentive		52													



## Appendix D: Rate Model

SD Case Mix Rate Model v1.9 for SDDHS, Cost Center Assignment

Center	Inflate?	Cost Center Title	Center	Inflate?	Description	Center	Inflate?	Description
0		Not Assigned (Totals etc.)	2	Y	B-9 Other Dietary Salaries Salaries	4	Y	D-1 Worker's Comp Other
1A		Direct Care - Non-Therapy	2	Y	B-10 Dietary Consultant Fees Other	4	Y	D-2 Unemp. Ins Other
1B		Direct Care - Therapy	2	Y	B-11 Dietary Supplies Other	4	Y	D-3 Real Estate Taxes Other
2		Health and Subsistence	2	Y	B-12 Food Purchases Other	4	Y	D-4 Patient Care/Med Related Travel Other
3		General Administrative	2	Y	B-13 Laundry Supervisor Salaries	0	Y	D-5 Total Other Operating Other
4		Other Operating	2	Y	B-14 Other Laundry Salaries Salaries	0	Y	D-5 Total Other Operating Adj Total
5		Plant/Operational	2	Y	B-15 Laundry Supplies Other	5	Y	E-1 Maint Supervisor Salaries
6		Capital	2	Y	B-16 Nursing Aide Training Costs Other	5	Y	E-2 Other Maint Salaries Salaries
7		Other	2	Y	B-17 Nursing Aide Testing Costs Other	5	Y	E-3 Maint Supplies & Repairs Other
1A	Y	A-1 RN Salaries	2	Y	B-18 Inservice Training Director Salaries	5	Y	E-4 Housekeeping Salaries Salaries
1A	Y	A-2 LPN Salaries	2	Y	B-19 Inservice Training Personnel Salaries	5	Y	E-5 Other Housekeeping Salaries Salaries
1A	Y	A-3 Nurse Aides Salaries	2	Y	B-20 Inservice Training Contracted Other	5	Y	E-6 Housekeeping Supplies Other
1A	Y	A-4 Nursing Supplies Other	2	Y	B-21 Inservice Training Other Other	5	Y	E-7 Utilities Other
1B	Y	A-5 OT Salaries	2	Y	B-22 FICA Other	5	Y	E-8 Interest- Working Capital Other
1B	Y	A-5 OT Other	2	Y	B-23 Employee Fringe Benefits Other	5	Y	E-9 Vehicle Supplies & Repairs Other
1B	Y	A-6 ST Salaries	2	Y	B-24 Other Emp F/B Vaccin, Physicals Other	5	Y	E-10 Vehicle Insurance Other
1B	Y	A-6 ST Other	2	Y	B-25 Other Health And Subsistence Salaries	5	Y	E-11 Vehicle Deprec. Other
1B	Y	A-7 PT Salaries	2	Y	B-25 Other Health And Subsistence Other	5	Y	E-12 Vehicle Leases Other
1B	Y	A-7 PT Other	0	Y	B-26 Total Health And Subsistence Salaries	5	Y	E-13 FICA Other
1A	Y	A-8 Therapy Aides Salaries	0	Y	B-26 Total Health And Subsistence Other	5	Y	E-14 Emp Fringe Benefits Other
1A	Y	A-9 Therapy Supplies Other	0	Y	B-26 Total Health And Subsistence Adj Total	5	Y	E-15 Other Plant/Oper. Other
1A	Y	A-10 FICA Other	3	Y	C-1 Administrator Salaries	0	Y	E-16 Total Plant/Oper. Salaries
1A	Y	A-11 Emp Fringe Benefits Other	3	Y	C-2 Asst Administrator Salaries	0	Y	E-16 Total Plant/Oper. Other
1A	Y	A-12 Other Dir Pt Care Other	3	Y	C-3 Office Salaries Salaries	0	Y	E-16 Total Plant/Oper. Adj Total
0	Y	A-13 Total Dir Pt Care Salaries	3	Y	C-4 Non-Owner's Directors Fees Other	6	N	F-1 Building Insurance Other
0	Y	A-13 Total Dir Pt Care Adj Total	3	Y	C-5 Office Supplies Other	6	N	F-2 Building Deprec. Other
2	Y	B-1 DON Salaries	3	Y	C-6 Postage Expense Other	6	N	F-3 Furniture & Equip Deprec Other
2	Y	B-2 Medical Records Salaries	3	Y	C-7 Telephone Expense Other	6	N	F-4 Amort. (Org/Pre-Oper.) Other
2	Y	B-2 Medical Records Other	3	Y	C-8 Advertising Expense Other	6	N	F-5 Interest-Mortgage Other
2	Y	B-3 Activities/Act. Consultant Salaries	3	Y	C-9 Central Office Expense Other	6	N	F-6 Rent- Facility & Grounds Other
2	Y	B-3 Activities/Act. Consultant Other	3	Y	C-10 Legal & Accounting Expense Other	6	N	F-7 Rent- Equip. Other
2	Y	B-4 Social Services Salaries	3	Y	C-11 Professional Liability Expense Other	0	N	F-8 Total Capital Expenditures Other
2	Y	B-4 Social Services Other	3	Y	C-12 Dues, Fees, Licenses, & Subscript Other	0	N	F-8 Total Capital Expenditures Adj Total
2	Y	B-5 Chaplaincy Salaries	3	Y	C-13 Admin. Travel Other	0	Y	G-1 Total Direct Care (Sec. A) Salaries
2	Y	B-5 Chaplaincy Other	3	Y	C-14 FICA Other	0	Y	G-1 Total Direct Care (Sec. A) Other
2	Y	B-6 Barber/Beautician Salaries	3	Y	C-15 Emp. Fringe Benefits Other	0	Y	G-1 Total Direct Care (Sec. A) Adj Total
2	Y	B-6 Barber/Beautician Other	3	Y	C-16 Other Admin. Other	0	Y	G-2 Total Non-Direct Care (Sec. B-E) Salaries
2	Y	B-7 Medical, Dental, & Pharm Cons Other	0	Y	C-17 Total Admin. Salaries	0	Y	G-2 Total Non-Direct Care (Sec. B-E) Other
2	Y	B-8 Dietician/Dietary Supervisor Salaries	0	Y	C-17 Total Admin. Other	0	Y	G-2 Total Non-Direct Care (Sec. B-E) Adj Total
			0	Y	C-17 Total Admin. Adj Total	0	Y	G-3 Total Capital Expenditures (Sec. F.) Other
						0	Y	G-3 Total Capital Expenditures (Sec. F.) Adj Total
						0	Y	G-4 Total Reported Costs Salaries
						0	Y	G-4 Total Reported Costs Other
						0	Y	G-4 Total Reported Costs Adj Total
						0	Y	H-1 Return On Net Equity Other
						0	Y	H-2 Total Recognized Costs Salaries
						0	Y	H-2 Total Recognized Costs Other
						0	Y	H-2 Total Recognized Costs Adj Total

Inflate

Y

N



## Appendix D: Rate Model

Medicaid Nursing Home Rate Methodology Review  
Draft 1 - July 17, 2020

South Dakota Nursing Facility Case Mix Rate Model  
Parameter Settings Scenarios Comparison

Date:   
Reviewer:

		Scenarios				
Rate Area	Parameter	Current w/ 8% Inc Limit	Current w/out Inc Limit	Modeled Parameters	Preferred Option 1	Preferred Option 2
General	Inflation Index	CPI	CPI	CPI		
	Inflation Through Date	12/31/2020	12/31/2020	12/31/2020		
	Small Facility Bed Ct	60	60	60		
Direct Care	Type of Rate	Cost - Ceilings	Cost - Ceilings	Cost - Ceilings		
	Occupancy Rule	Y	Y	Y		
	Overall CMI Calc.	Exclude Mdcr	Exclude Mdcr	Exclude Mdcr		
	Medicaid CMI Source	2018	2018	2018		
	Exclude CMI <1.0 from Limit	Y	Y	Y		
	Max Ceiling Rate	125%	125%	125%		
	Min Ceiling Rate	115%	115%	115%		
General Admin	Type of Rate	Cost - Ceilings	Cost - Ceilings	Cost - Ceilings		
	Occupancy Rule	Y	Y	Y		
	Include with NDC	N	N	N		
	Exclude CMI <1.0 from Limit	Y	Y	Y		
	Exclude Chains	Y	Y	Y		
	Max Ceiling Rate	110%	110%	110%		
	Min Ceiling Rate	105%	105%	105%		
Combined NDC	Type of Rate	Cost - Ceilings	Cost - Ceilings	Cost - Ceilings		
	Occupancy Rule	Y	Y	Y		
	Exclude CMI <1.0 from Limit	Y	Y	Y		
	Max Ceiling Rate	110%	110%	110%		
	Min Ceiling Rate	105%	105%	105%		
Capital	Type of Rate	Current	Current	Current		
Value Based	Est. Fiscal Impact	\$0	\$0	\$1,887,863		
Purchasing	Percent of Total Expend.	0.00%	0.00%	1.05%		
Overall	Impose Increase Limit	Y	N	Y		
	Increase Limit Percentage	8%	0%	8%		
	Estimated Cost	\$177,837,441	\$205,865,739	\$179,983,074		
	Weighted Avg. Rate	\$169.99	\$196.79	\$172.05		
	Average Cost Coverage	84.87%	97.76%	84.98%		
Notes	Record further explanation of base and VBP parameters modeled.	Calculates rebased rates using the current NF rate methodology.	Calculates rebased rates using the current NF rate methodology without the 8% overall rate increase limit.	Calculates rebased rates using the current NF rate methodology and a VBP add-on based on 5-Star staffing and QM scores with exclusions for health inspection ratings below 3.		



### Appendix E: FRV Models

In order to provide nursing facility services an entity must possess a building and equipment that meet strict specifications. Medicaid reimbursement for these things is generally covered through a capital component of the Medicaid rate. This component may also cover other costs related to the ownership of the nursing facility such as property taxes and insurance. States have flexibility in determining how the capital component of the Medicaid rate is established. Some states rely on reported costs to set facility-specific capital per diems, others use pricing systems to establish statewide or regional rates. Another common methodology is a fair rental value (FRV) system.

An FRV system attempts to determine the value of a nursing facility and provide a reasonable rate of return on that value. There are two primary methods for determining the value of a nursing facility for an FRV system. One involves conducting appraisals of each nursing facility. An Appraisal FRV system is often conducted through a contracted appraisal firm. It can involve a very lengthy process and can be considered somewhat subjective since it relies on individual appraiser's assessment of the value of each nursing facility. Another method is to establish a value for new construction, then use facility-specific information to determine the depreciable age of each nursing facility, and then use these two pieces of information to establish the present value of the facility. This Depreciable Age FRV methodology was explored through the stakeholder workgroup discussions.

The primary component of a depreciable age FRV system is the value of new construction per nursing facility bed. This amount can be established through reviews of recent construction projects or the use of a construction index such as RS Means. An allowance for equipment is usually added to the value of constructing a new bed. Other inputs include the age of each nursing facility and an annual depreciation factor. The calculation is fairly straight forward with the total value of the facility calculated by multiplying the per bed value of new construction and equipment by the total number of beds for the facility. This amount is then reduced for the cumulative depreciation determined based on the age of the facility. Annual depreciation is often set at 1-2.5% per year. A rental factor or rate of return is then applied to the depreciated facility value. The rental factor usually ranges between 6% and 10% and is often tied to a standard benchmark such as the 30-year U.S. Treasury Bill rate of return plus 2%.

The age of the nursing facility is generally determined using the construction date of the facility with adjustments made to account for new additions and renovations that have occurred since the original construction. New additions and renovations reduce the age of the nursing facility through a weighted average calculation. For example a 40-year old facility with a total of 60 beds, 30 of which were added 20 years after the original construction would be treated as a 30 year old facility (30 beds at 40 years + 30 beds at 20 years = 60 beds at 30 years).

Renovations can also reduce the age of the facility by creating a new bed equivalent for each multiple of the new bed construction/equipment value that is expended on the renovation. For example, if a renovation occurred today that cost \$800,000, and the new bed construction/equipment value was



\$80,000, the renovation would essentially replace 10 beds at “0” years of age. Going back to the example of a 60-bed facility aged at 30 years (original construction plus addition), the renovation would reduce the age to 25 years (50 beds at 30 years + 10 beds at 0 years). Thus in addition to a value for new construction/equipment costs, and the original construction date, it is also necessary to collect information on additions and renovations in order to properly calculate the age of each facility.

For the purposes of the workgroup investigations we used data from the state that included a calculated facility age accounting for some new additions and/or building renovations. However, it was understood that this data would need to be reviewed and updated before an FRV system could be implemented. We also used estimated new construction/equipment costs and variable amounts for depreciation and fair rental rates. This allowed the workgroup to review how these calculations would work but again the input data would need considerable refinement before it could be implemented.

The advantages of an FRV system are the ability to tie the reimbursement to the value of the building rather than the cost incurred by the provider, and the incentive it provides for building improvements. Implementing an FRV system would require additional research and modeling but would almost certainly strengthen the Medicaid payment system.



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## Appendix F: BIMS/CPS Information

One of the ongoing concerns discussed during the stakeholder workgroup meetings is the administrative burden tied to extraordinary care payments. Currently, most extraordinary care payment requests require the facility to submit extensive documentation that is then reviewed by the Department staff to determine if an extraordinary care payments should be allowed. One option considered for automating some of this process is to utilize the RUG III Cognitive Performance Scale (CPS).

The CPS is used in the RUG III Classification System to measure a resident's cognitive performance. CPS scoring ranges from 0 to 6, with 0 indicating intact cognitive function, and 6 representing very severe impairment. The score is developed from 5 MDS items including; B1-Comatose, B2a-Short Term Memory, B4-Cognitive Skills for Decision Making, C4-Making Self Understood, and G1hA-Eating ADL: Self Performance. Individuals with a CPS score of 5 or higher were considered in need of additional care and included in the count of residents for each facility that might trigger extraordinary care payments.

The Brief Interview of Mental Status is another measure of cognitive function that may be reported on the MDS. When it is reported some of the items needed to compute the CPS are not assessed. Therefore a crosswalk was developed by CMS which is used when the BIMS is completed. This enables a CPS score to be determined.

The BIMS test is used to provide a quick assessment of cognitive function. The test includes components to assess immediate recall of information, orientation, and short-term memory. These components can be scored from questions included on the MDS assessment and therefore a BIMS score can be generated quarterly for each nursing facility resident. This provides a means to assess current cognitive function as well changes in cognitive function.

The test for immediate recall involves asking the individual to repeat three words spoken to them. Scoring for this component is one point for each correctly repeated word for a maximum of 3 points.

The test for orientation includes asking the individual to state the current month, year, and day of the week. A total of 6 points is available for this component with greater emphasis placed on correctly identifying the year, and the least emphasis placed on correctly identifying the day of the week.

The final component of the BIMS is short-term memory. The person is asked to again repeat the three words that were introduced during the immediate recall assessment. Cues are provided if the person does not remember the words. Scoring for this component can total to a maximum of 6 points, with 2 points awarded for each word recalled without a cue, 1 point given for words recalled with a cue, and 0 points for words that are not recalled.

The total BIMS score is used to interpret cognitive function with 13-15 points considered intact cognition, 8-12 points considered moderate impairment, and 0-7 points considered severe impairment.

**Need data**



## Appendix G: Medicaid Cost Report

Medicaid Nursing Home Rate Methodology Review  
Draft 1 - July 17, 2020

### Appendix G: Medicaid Cost Report

#### STATISTICAL AND COST SUMMARY FOR LONG TERM CARE FACILITIES SUMMARY SCHEDULE

##### I. GENERAL INFORMATION

1. MEDICAL VENDOR NUMBER 0000000  
2. FACILITY NAME..... FACILITY NAME  
3. ADDRESS..... FACILITY ADDRESS  
4. ZIP CODE..... 00000 5. TELEPHONE... .. 000-000-0000  
6. ACCOUNTING PERIOD COVERED BY THIS REPORT.... 1/1/2018 TO 12/31/2018

##### II. TYPE OF OWNERSHIP

A. NONPROFIT CORP.  
1. CHARITABLE.....  
2. OTHER NON-PROFIT..  
B. PROPRIETARY  
1. PARTNERSHIP..  
2. INDIVIDUAL..  
3. CORPORATION..  
C. NAME AND ADDRESS OF OWNER  
(Required of all Facilities)  
PLAINS COMMERCE BANK  
3905 W 49TH STREET  
SIOUX FALLS, SD 57106  
D. NAME AND ADDRESS OF MANAGEMENT COMPANY  
(If applicable)  
CARING PROFESSIONALS  
48065 JASPER STREET  
DELL RAPIDS, SD 57022

##### III. STATISTICS

1. TOTAL LICENSED NURSING HOME BED CAPACITY AT BEGINNING OF YEAR..... 21  
2. Additional Licensed Nursing Home Beds Added During The Year - Number.... 2 Date..... 8/9/18  
3. Reduction of Nursing Home Licensed Beds During The Year - Number..... 2 Date..... 2/13/18  
4. TOTAL POSSIBLE NURSING HOME LICENSED RESIDENT DAYS..... 7500  
5. TOTAL RESIDENT DAYS (From Schedule O, Line 17)..... 6450  
6. PERCENTAGE OF OCCUPANCY (Line 5 Divided by Line 4)..... 86 %  
7. ENTER LINE 5 OR \_\_\_\_ OF LINE 4 WHICHEVER IS LARGER..... DEPT

##### IV. TO BE COMPLETED BY THE DEPARTMENT

\*1. TOTAL RECOGNIZED DIRECT CARE COSTS (Schedule A, Section A)..... 555833  
\*2. TOTAL NON-DIRECT CARE COSTS (Schedule A, Sec. B,C,D,E)..... 464017  
\*3. TOTAL CAPITAL COSTS (Schedule A, Section F)..... 6028  
\*4. TOTAL RECOGNIZED COSTS (Schedule A, Section H)..... .. 1025878

##### V. In the event there are further questions about this report, CONTACT:

\* 1. NAME..... NAME 2. TELEPHONE NUMBER..... 000-000-0000

FACILITY 2018 COST REPORT



## Appendix G: Medicaid Cost Report

Medicaid Nursing Home Rate Methodology Review  
Draft 1 - July 17, 2020

### SCHEDULE A CURRENT OPERATING COSTS

	DIRECT PATIENT CARE	EXPENSES PER TRIAL BALANCE	NON-PATIENT CARE ADJUSTMENT	PATIENT CARE ADJUSTMENT	SALARIES	OTHER	ADJUSTED TOTAL
A-1	Registered Nurses	116,136	(9,526)	(30,462)	76,148	XXXXXXXXXX	XXXXXXXXXX
A-2	L.P.N.'s	105,375			105,375	XXXXXXXXXX	XXXXXXXXXX
A-3	Nurse Aides	211,838	(10,672)		201,166	XXXXXXXXXX	XXXXXXXXXX
A-4	Nursing Supplies	35,465	(2,509)		XXXXXXXXXX	32,956	XXXXXXXXXX
A-5	Occupational Therapy	22,592			0	22,592	XXXXXXXXXX
A-6	Speech Therapy	18,185			0	18,185	XXXXXXXXXX
A-7	Physical Therapy	28,023			0	28,023	XXXXXXXXXX
A-8	Therapy Aides	0			0	XXXXXXXXXX	XXXXXXXXXX
A-9	Therapy Supplies	6,865	(486)		XXXXXXXXXX	6,379	XXXXXXXXXX
A-10	FICA	0	(1,382)	27,575	XXXXXXXXXX	26,193	XXXXXXXXXX
A-11	Employee Fringe Benefits	169	(1,105)	21,892	XXXXXXXXXX	20,956	XXXXXXXXXX
A-12	Other Direct Patient Care	19,220	(1,360)		XXXXXXXXXX	17,860	XXXXXXXXXX
A-13	TOTAL DIRECT PATIENT CARE	563,868	(27,040)	19,005	382,689	173,144	555,833
HEALTH AND SUBSISTENCE							
B-1	Director of Nursing	49,341	(3,491)		45,850	XXXXXXXXXX	XXXXXXXXXX
B-2	Medical Records	0	(12,288)	30,462	18,174	0	XXXXXXXXXX
B-3	Activities/Activities Consultant	25,502	(10,287)		13,830	1,385	XXXXXXXXXX
B-4	Social Services	22,907	(9,240)		12,987	680	XXXXXXXXXX
B-5	Chaplaincy	0			0	0	XXXXXXXXXX
B-6	Barber and Beautician	0			0	0	XXXXXXXXXX
B-7	Medical/Dental & Pharmacy Consultant	6,685	(2,697)		XXXXXXXXXX	3,988	XXXXXXXXXX
B-8	Dietician/Dietary Supervisor	34,709	(14,001)		20,708	XXXXXXXXXX	XXXXXXXXXX
B-9	Other Dietary Salaries	79,560	(32,093)		47,467	XXXXXXXXXX	XXXXXXXXXX
B-10	Dietary Consultant Fees	5,549	(2,238)		XXXXXXXXXX	3,311	XXXXXXXXXX
B-11	Dietary Supplies	3,576	(1,442)		XXXXXXXXXX	2,134	XXXXXXXXXX
B-12	Food Purchases	75,510	(29,839)	(2,537)	XXXXXXXXXX	44,134	XXXXXXXXXX
B-13	Laundry Supervisor	0			0	XXXXXXXXXX	XXXXXXXXXX
B-14	Other Laundry Salaries	26,021	(10,496)		15,525	XXXXXXXXXX	XXXXXXXXXX
B-15	Laundry Supplies	273	(110)		XXXXXXXXXX	163	XXXXXXXXXX
B-16	Nurse Aide Training Costs (75 HR)	0			XXXXXXXXXX	0	XXXXXXXXXX
B-17	Nurse Aide Testing Costs	0			XXXXXXXXXX	0	XXXXXXXXXX
B-18	Inservice Training Director	0			0	XXXXXXXXXX	XXXXXXXXXX
B-19	Inservice Training Personnel	0			0	XXXXXXXXXX	XXXXXXXXXX
B-20	Inservice Training - Contracted	0			XXXXXXXXXX	0	XXXXXXXXXX
B-21	Inservice Training - Other	0			XXXXXXXXXX	0	XXXXXXXXXX
B-22	FICA	0	(6,194)	18,140	XXXXXXXXXX	11,946	XXXXXXXXXX
B-23	Employee Fringe Benefits	3,038	(6,128)	14,402	XXXXXXXXXX	11,312	XXXXXXXXXX
B-24	Other Empl F/B Vaccin.,Physicals	0			XXXXXXXXXX	0	XXXXXXXXXX
B-25	Other Health and Subsistence	205	(83)		0	122	XXXXXXXXXX
B-26	TOTAL HEALTH AND SUBSISTENCE	333,876	(140,627)	60,467	174,541	79,175	253,716
GENERAL ADMINISTRATIVE							
C-1	Administrator	0	(18,109)	44,892	26,783	XXXXXXXXXX	XXXXXXXXXX
C-2	Assistant Administrator	0			0	XXXXXXXXXX	XXXXXXXXXX
C-3	Office Salaries	80,317	(14,290)	(44,892)	21,135	XXXXXXXXXX	XXXXXXXXXX
C-4	Non-Owner's Directors Fees	0			XXXXXXXXXX	0	XXXXXXXXXX
C-5	Office Supplies	0			XXXXXXXXXX	0	XXXXXXXXXX
C-6	Postage Expense	800	(323)		XXXXXXXXXX	477	XXXXXXXXXX
C-7	Telephone Expense	6,957	(2,806)		XXXXXXXXXX	4,151	XXXXXXXXXX
C-8	Advertising Expense	7,596		(7,596)	XXXXXXXXXX	0	XXXXXXXXXX
C-9	Central Office Expense	0			XXXXXXXXXX	0	XXXXXXXXXX
C-10	Legal & Accounting Expense	0			XXXXXXXXXX	0	XXXXXXXXXX
C-11	Professional Liability Expense	0	(3,957)	9,809	XXXXXXXXXX	5,852	XXXXXXXXXX
C-12	Dues,Fees,Licenses, & Subscriptions	5,641	(2,068)	(514)	XXXXXXXXXX	3,059	XXXXXXXXXX
C-13	Administrative Travel	378	(152)		XXXXXXXXXX	226	XXXXXXXXXX
C-14	FICA	55,427	(2,218)	(49,929)	XXXXXXXXXX	3,280	XXXXXXXXXX
C-15	Employee Fringe Benefits	49,310	(3,901)	(39,639)	XXXXXXXXXX	5,770	XXXXXXXXXX
C-16	Other Administrative	98,005	(25,777)	(34,102)	XXXXXXXXXX	38,126	XXXXXXXXXX
C-17	TOTAL ADMINISTRATIVE SERVICES	304,431	(73,601)	(121,971)	47,918	60,941	108,859
OTHER OPERATING							
D-1	Worker's Compensation	26,628	(10,741)		XXXXXXXXXX	15,887	XXXXXXXXXX
D-2	Unemployment Insurance	2,088	(842)		XXXXXXXXXX	1,246	XXXXXXXXXX
D-3	Real Estate Taxes	6,475	(2,612)		XXXXXXXXXX	3,863	XXXXXXXXXX
D-4	Patient Care/Medical Related Travel	0			XXXXXXXXXX	0	XXXXXXXXXX
D-5	TOTAL OTHER OPERATING	35,191	(14,195)	0	XXXXXXXXXX	20,996	20,996



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PLANT/OPERATIONAL									
E-1	Maintenance Supervisor	42,957	(17,328)		25,629	XXXXXXXXXX	XXXXXXXXXX		
E-2	Other Maintenance Salaries	0			0	XXXXXXXXXX	XXXXXXXXXX		
E-3	Maintenance Supplies & Repairs	25,267	(10,192)			XXXXXXXXXX	15,075	XXXXXXXXXX	
E-4	Housekeeping Supervisor	0			0	XXXXXXXXXX	XXXXXXXXXX		
E-5	Other Housekeeping Salaries	18,606	(7,505)		11,101	XXXXXXXXXX	XXXXXXXXXX		
E-6	Housekeeping Supplies	0				XXXXXXXXXX	0	XXXXXXXXXX	
E-7	Utilities (Heat & Other)	34,416	(13,883)			XXXXXXXXXX	20,533	XXXXXXXXXX	
E-8	Interest - Working Capital	0				XXXXXXXXXX	0	XXXXXXXXXX	
E-9	Vehicle Supplies & Repairs	0				XXXXXXXXXX	0	XXXXXXXXXX	
E-10	Vehicle Insurance	0				XXXXXXXXXX	0	XXXXXXXXXX	
E-11	Vehicle Depreciation	0				XXXXXXXXXX	0	XXXXXXXXXX	
E-12	Vehicle Leases	0				XXXXXXXXXX	0	XXXXXXXXXX	
E-13	FICA	0	(1,700)	4,214		XXXXXXXXXX	2,514	XXXXXXXXXX	
E-14	Employee Fringe Benefits	1,102	(1,794)	3,345		XXXXXXXXXX	2,653	XXXXXXXXXX	
E-15	Other Plant/Operational	4,930	(1,989)			XXXXXXXXXX	2,941	XXXXXXXXXX	
E-16	TOTAL PLANT/OPERATIONAL	127,278	(54,391)	7,559	36,730		43,716	80,446	
CAPITAL									
F-1	Building Insurance	6,664	(2,688)			XXXXXXXXXX	3,976	XXXXXXXXXX	
F-2	Building Depreciation	0				XXXXXXXXXX	0	XXXXXXXXXX	
F-3	Furniture & Equipment Depreciation	0				XXXXXXXXXX	0	XXXXXXXXXX	
F-4	Amort.(Organization/Pre-Operating)	0				XXXXXXXXXX	0	XXXXXXXXXX	
F-5	Interest - Mortgage	0				XXXXXXXXXX	0	XXXXXXXXXX	
F-6	Rent - Facility & Grounds	0				XXXXXXXXXX	0	XXXXXXXXXX	
F-7	Rent - Equipment	3,440	(1,388)			XXXXXXXXXX	2,052	XXXXXXXXXX	
F-8	TOTAL CAPITAL EXPENDITURES	10,104	(4,076)	0		XXXXXXXXXX	6,028	6,028	
G-1	*TOTAL DIRECT CARE (SEC. A)	563,868	(27,040)	19,005	382,689		173,144	555,833	
G-2	*TOTAL NON-DIRECT CARE(SEC.B,C,D,E)	800,776	(282,814)	(53,945)	259,189		204,828	464,017	
G-3	*TOTAL CAPITAL EXPENDITURES(SEC. F)	10,104	(4,076)	0		XXXXXXXXXX	6,028	6,028	
G-4	*TOTAL REPORTED COSTS	1,374,748	(313,930)	(34,940)	641,878		384,000	1,025,878	
H-1	*Return on Net Equity	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX		0	XXXXXXXXXX	
H-2	*TOTAL RECOGNIZED COSTS	1,374,748	(313,930)	(34,940)	641,878		384,000	1,025,878	

\*(To be Completed by the Dept.)  
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### SCHEDULE B

#### RELATED ORGANIZATION COST ALLOCATION

I. Are there any costs included in this report which are direct charges or were derived from allocations of central office or parent or related organization costs?

YES

☒ NO

II. NAME OF RELATED ORGANIZATION.....

III. Show the allocation of costs below (see instructions). If necessary, please attach worksheets.

	COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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SCHEDULE C REVENUE				
	1 Revenue Per General Ledger	2 Amt. of Revenue Used to Offset Cost on Sched A	3 Net Revenue	4 Line Number Offset
<b>PATIENT REVENUE</b>				
I. Revenue Received				
1. Rm. Bd. & Care - Medicaid/Co-Pay	\$813,545		\$813,545	
2. Rm. Bd. & Care - Medicare	\$67,808		\$67,808	
3. Rm. Bd. & Care - Private Pay	\$429,994		\$429,994	
4. Rm. Bd. & Care - Veterans			\$0	
5. Rm. Bd. & Care - Supervised Living			\$0	
6. TOTAL PATIENT REVENUE	\$1,311,347	\$0	\$1,311,347	
II. Ancillary Revenue				
1. Prescription Drugs			\$0	
2. Medical Supplies			\$0	
3. Therapy Services			\$0	
4. Oxygen			\$0	
5. X-Ray & Laboratory			\$0	
6. Other			\$0	
7. OBRA Payments			\$0	
8. TOTAL	\$0	\$0	\$0	
III. Other Operating Revenues				
1. Non-Patient Meals	\$2,403	\$2,403	\$0	B-12
2. Telephone			\$0	
3. Services & supplies sold to employees or others			\$0	
4. Barber & Beauty			\$0	
5. Crafts			\$0	
6. Pop & Candy	\$134	\$134	\$0	B-12
7. Rental of Facility Space			\$0	
8. Rental of Equipment			\$0	
9. Laundry Service to Employees			\$0	
10. Job Services Internship			\$0	
11. Donated Commodities			\$0	
12. Private Duty Nurses' Fees			\$0	
13. Interest & Other Investment Income			\$0	
14. Other	\$9,738	\$9,738	\$0	C-16
15. TOTAL OTHER OPERATING REVENUE	\$12,275	\$12,275	\$0	
IV. Non-Operating Revenue				
1. Gifts, Donations			\$0	
2. Government Grants			\$0	
3. Other			\$0	
4. TOTAL NON-OPERATING REVENUE	\$0	\$0	\$0	
V. TOTAL REVENUE (Add Lines I.6, II.8, III.15, and IV.4).....	\$1,323,622	\$12,275	\$1,311,347	

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### SCHEDULE D

(To Be Completed By Proprietary Homes Only)

Indicate "X" if not applicable.....

Computation of growth and improvement factor as an allowable cost.

1. Total Assets (From Schedule E, Line 17).....	867208	
Less:		
2. Investments.....	0	
3. Assets not used in care of patients.....	0	
4. Excessive accumulation of cash.....	0	
5. Funded depreciation.....	0	
6. Self insurance reserve fund(s).....	0	
7. Goodwill.....	0	
8. Receivable from owners, partners, stockholders, & related organizations (incl. central office).	0	
9. Other (Specify)	0	
10. Total Deductions (Add Line 2 thru Line 9) .....	0	
11. Net Assets (Line 1 minus Line 10).....	867208	
12. Total Liabilities (From Sched. E, Line 28).....	1847009	
Less:		
13. Amount due to owners, partners, stockholders, & related organizations (incl. central office)	0	
14. Other (Specify)	0	
15. Total Deductions (Line 13 add Line 14).....	0	
16. Net Liabilities (Line 12 minus Line 15).....	1847009	
17. Tentative Equity (Line 11 minus Line 16).....	-979801	
18. Central Office Equity (Attach workpaper).....	0	
19. Adjusted Net Equity (Line 17 add Line 18).....	-979801	
20. Adjusted Net Equity Not Related to Patient Care..... (Attach workpaper)	0	
21. Adjusted Net Equity Related to Patient Care..... (Line 19 minus Line 20)	-979801	
22. Rate of Return *.....		
23. Return on Net Equity *.....	0	
* To be completed by the Department		

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SCHEDULE E - BALANCE SHEET	
<b>Assets</b>	
1. Cash - Unrestricted.....	-9460
2. Cash - Restricted.....	0
3. Accounts Receivable.....	86668
4. Other Receivables.....	0
5. Prepaid Expenses.....	0
6. Inventories.....	0
7. Fixed Assets.....	0
8. Land.....	0
9. Buildings and Improvements.....	790000
10. Less Allowance for Depreciation.....	0
11. Furnishings and Equipment.....	0
12. Less Allowance for Depreciation.....	0
13. Other Assets (Specify)	0
14.	0
15.	0
16.	0
17. Total Assets.....	867208
<b>Liabilities and Fund Balance</b>	
18. Accounts Payable.....	17104
19. Salaries Payable.....	0
20. Payroll Taxes Payable.....	18062
21. Vacation/Sick Benefits Payable.....	0
22. Notes Payable.....	0
23. Mortgage Payable.....	0
24. Other Payables (Specify)	1151808
25. Long Term Liabilities	660035
26.	0
27.	0
28. Total Liabilities.....	1847009
29. Fund Balance - Unrestricted.....	-979801
30. Fund Balance - Restricted.....	0
31. Total Fund Balance.....	-979801
32. Total Liabilities and Fund Balance.....	867208

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### SCHEDULE F STAFFING AND SALARY COSTS (This schedule must cover the entire reporting period)

	1	2	3	4	5
	Sch. A Line No.	Salaries	Hours	FICA	Fringe Benefits
RN's	A-1	\$76,148	2845	\$5,212	\$4,166
LPN's	A-2	\$105,375	5929	\$7,212	\$5,765
Nurse Aides	A-3	\$201,166	15486	\$13,769	\$11,006
Occupational Therapy	A-5				
Speech Therapy	A-6				
Physical Therapy	A-7				
Therapy Aides	A-8				
DON	B-1	\$45,850	1528	\$3,138	\$2,508
Medical Records Staff	B-2	\$18,174	665	\$1,244	\$987
Activities Staff	B-3	\$13,830	946	\$947	\$752
Social Services Staff	B-4	\$12,987	651	\$889	\$2,494
Chaplaincy	B-5				
Barber/Beautician	B-6				
Dietary Supervisor	B-8	\$20,708	1242	\$1,418	\$1,125
Dietary Staff	B-9	\$47,467	4559	\$3,249	\$2,579
Laundry Supervisor	B-13				
Laundry Staff	B-14	\$15,525	1247	\$1,063	\$844
Inservice Training Director	B-18				
Inservice Training Staff	B-19				
Other Health & Subsistence	B-25				
Administrator	C-1	\$26,783	940	\$1,833	\$3,225
Assistant Administrator	C-2				
Office Staff	C-3	\$21,135	1267	\$1,447	\$2,545
Maintenance Supervisor	E-1	\$25,629	1223	\$1,754	\$1,082
Maintenance Staff	E-2				
Housekeeping Supervisor	E-4				
Housekeeping Staff	E-5	\$11,101	1040	\$759	\$469

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### SCHEDULE G

Statement of Compensation and Other Payments to Owners, Relatives, and Members of Board of Directors

NOTE: ALL Owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

Indicate "X" here if N/A.....

1	2	3	4	5	6
Name	Title	Ownership Interest in Nursing Homes	Compensation Received *	Avg Hrs Per Work Week Devoted to this Bus. & % of Total Work Wk. Hours Percent	Compensation Included in Costs for this Reporting Period ** Descript. Amount
1					
2					
3					
4					
5					
6					
7					
8					
9					TOTAL..... 0

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes(s), and/or related organization(s), attach a schedule detailing the name(s) of the homes and/or organizations as well as the amount paid. This amount must agree to the amounts claimed on the other nursing homes' cost reports.

\*\* This must include all forms of compensation paid by related entities. FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES, AND ALL MANAGEMENT COMPANIES, MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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### SCHEDULE H LEASES

RENTAL COSTS Indicate "X" here if N/A.....

#### I. Building and Fixed Equipment

1. Name of Party Holding Lease:.....

Address of Party Holding Lease:.....

2. Does the facility also pay real estate taxes in addition to rental amount  
shown below on Line 7, Column 4?.....

YES

NO

	1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Yrs of Lease	6 Total Yrs Renewal Opt.
3. Original Building	1972	36				
4. Additions						
5.						
6. TOTAL	XXXXXXXXXX	36	XXXXXXXXXX	0	XXXXXXXXXX	XXXXXXXXXX

7. Rent to be paid in future years under the current rental agreement.

	Fiscal Yr Ending	Annual Rent
8.		\$0
9.		\$0
10.		\$0

#### II. Equipment -- Excluding Transportation Equipment.

	Description	Purpose	Monthly Lease Pmt	Rental Exp This Period
1.	Copier	Office	\$287	\$3,440
2.				
3.				
4.				

#### III. Vehicle Rental

	Purpose of Vehicle	Model Yr. and Make	Monthly Lease Pmt	Rental Exp This Period
1.				
2.				
3.				

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### SCHEDULE I

#### SCHEDULE I-1

Detail of Other Direct Patient Care - Schedule A, Line A-12, Column 1

Description	Amount
Nursing - Travel/Milage	\$3,063
Nursing - Equipment Purchase	\$3,233
Nursing - Professional Fees	\$380
Nursing - Pharmaceuticals	\$9,475
Nursing - Dues & Subscriptions	\$590
Nursing - Education/Training	\$2,479
	\$0
	\$0
	\$0
Total Reported.....	\$19,220

#### SCHEDULE I-2

Detail of Other Health & Subsistence - Schedule A, Line B-25, Column 1

Description	Amount
Dietary - Education/Training	\$171
Dietary - Travel/Milage	\$34
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
Total Reported.....	\$205

#### SCHEDULE I-3

Detail of Administrative Travel - Schedule A, Line C-13, Column 1

Description	Amount
Administration - Travel/Milage	\$378
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
	\$0
Total Reported.....	\$378



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### SCHEDULE I-4

Detail of Other Administrative - Schedule A, Line C-16, Column 1

Description	Amount
Administration - Bad Debt Expense	\$14,353
Administration - Bank Service Charge	\$191
Administration - Cash	\$593
Administration - Contributions	\$205
Administration - Education/Training	\$425
Administration - Liability Insurance	\$9,809
Administration - Res Fund Surety Bond	\$200
Administration - Professional Fees	\$4,797
Administration - Professional Fees	\$1,518
Administration - Professional Fees Consulting	\$15,837
Administration - Professional Fees Management Fees	\$41,631
Administration - Refunds	\$4,726
Administration - Supplies	\$2,653
Administration - Taxes	\$854
Administration - Background Checks	\$213
Total Reported.....	\$98,005

### SCHEDULE I-5

Detail of Other Plant & Operational - Schedule A, Line E-15, Column 1

Description	Amount
Environmental Services - Equip Purchase/Rental	\$50
Environmental Services - Lawn Care	\$1,068
Environmental Services - Professional Services	\$3,619
Environmental Services - Travel/Milage	\$193
	\$0
	\$0
	\$0
	\$0
	\$0
Total Reported.....	\$4,930

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### SCHEDULE M CHANGE OF OWNERSHIP OR OPERATOR

1. Specify the date your organization began operating the nursing facility..... 12/1/2013

2. If your organization or related organization currently owns the building facilities,  
specify the date the facilities were purchased. (Indicate "N/A" if building not owned)... N/A

Lines 3 through 22 of this form are to be completed by those homes which have had a change of  
ownership or operator since July 18, 1984.

3. Furniture & Equip. Depreciation (Sched. A, Line F-3, Col. 5)..... 0

Less Depreciation on:

4. Purchases made between 1984-2015..... 0

5. Purchases made in 2016..... 0

6. Total Depreciation on Purchases (4 plus 5)..... 0

7. Depreciation Costs Related to Original Purchase (3 minus 6)..... 0

8. Vehicle Depreciation (Sched. A, Line E-11, Col. 5)..... 0

Less Depreciation on:

9. Purchases made between 1984-2015..... 0

10. Purchases made in 2016..... 0

11. Total Depreciation on Purchases (9 plus 10)..... 0

12. Depreciation Costs Related to Original Purchase (8 minus 11)..... 0

13. Building Depreciation (Sched. A, Line F-2, Col. 5)..... 0

Less Depreciation on Additions & Improvements:

14. Purchases made between 1984-2015..... 0

15. Purchases made in 2016..... 0

16. Total Depreciation Related to New Improvements (14 plus 15)..... 0

17. Depreciation Costs Related to Original Purchase (13 minus 16)..... 0

18. Interest Sched. A, Line E-8 & F-5, Col. 5)..... 0

Less Interest on Debt:

19. Incurred between 1984 - 2015..... 0

20. Incurred during 2016..... 0

21. Total Interest on New Debt (19 plus 20)..... 0

22. Interest Related to Original Debt (18 minus 21)..... 0

-----  
The balance of this form is to be completed by the Department of Social Services

23. Net Equity (Sched. D, Line 21)..... -979801

24. Net Equity When Ownership was Assumed..... 0

25. Net Equity Applicable to Change of Ownership  
(Lesser of Line 23 or 24).....

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### SCHEDULE N

#### INTEREST EXPENSE

Indicate "X" here if N/A....

Interest: (Complete details must be provided for each loan - include a separate schedule if necessary.)

	1 Mortgagee or Note Holder	2 Purpose of Loan	3 Monthly Payment Required	4 Date of Note	5 Amount of Note		6 Maturity Date	7 Interest Rate (4 digits)	8 Reporting Period Interest Exp.
					Original	Balance			
1.	A. Directly Facility Related Long Term								
2.	BANK [OWNER]	FACILITY	\$0	9/10/2013	\$660,035	\$660,035	None	0.0000	\$0
3.	BANK [OWNER]	FACILITY	\$0	12/1/2013	\$812,258	\$1,151,070	None	0.0000	\$0
4.			\$0		\$0	\$0			\$0
5.			\$0		\$0	\$0			\$0
6.	Working Capital	X	X	X	X	X	X	X	X
7.			\$0		\$0	\$0			\$0
8.			\$0		\$0	\$0			\$0
9.	Total Facility Related	X	\$0	X	\$1,472,293	\$1,811,105	X	X	\$0
10.	B. Non-Facility Related *	X	X	X	X	X	X	X	X
11.			\$0		\$0	\$0			\$0
12.			\$0		\$0	\$0			\$0
13.	Total Non-Facility Related	X	\$0	X	\$0	\$0	X	X	\$0
14.	TOTALS	X	\$0	X	\$1,472,293	\$1,811,105	X	X	\$0

\* Any interest expense reported in this section should be reported in Schedule A, Line E-8 & F-5, Column 2.

\*\* If there is ANY overlap in ownership between the facility and mortgagee or note holder, documentation must be attached.

FACILITY 2018 COST REPORT



## Appendix G: Medicaid Cost Report

Medicaid Nursing Home Rate Methodology Review  
Draft 1 - July 17, 2020

SCHEDULE O CENSUS QUESTIONNAIRE		
	YES	NO
1. Do you charge private pay patients for the day of death?		X
2. Do you charge private pay patients for the day of discharge?		X
3. Do you charge private pay patients for the day of admission?	X	
4. Do you offer private pay patients discounted rates for hospital and leave days?.....	X	
5. Have all Medicaid leave days been documented in the patient's medical file?.....	X	
6. Throughout the past year, have private pay patients paid daily rates greater than or equal to Medicaid rates?.....	X	
7. If answer to #6 is no, has the excess reimbursement been reported and paid back to the Department?.....	N/A	
8. Have all paid and physically present patient days been included in census data on Schedule O-1?.....	X	
9. Indicate the number of actual Medicare days provided and reported on Schedule O-1.....	152	
10. Total Resident Days (Schedule O-1, Line 27, Col. 13).....	10821	
11. Less Assisted Living Days.....	4365	
12. Net Resident Days (Line 10 minus 11).....	6456	
13. Less reserve bed days for hospital days in excess of five days per period of hospitalization. (Do not include supervised days previously adjusted on Line 11.).....	9	
14. Less days of death or discharge counted for private pay (Do not include supervised days previously adjusted on Line 11).....		
15. Less advance reserve bed days for holding bed prior to admission for private pay. Advance reserve days are defined as only for those residents who have not been a resident of your facility during the previous thirty days (Do not include supervised days previously adjusted on Line 11).....		
16. Less reserve bed days for which your charges are less than 50% of your normal charges. (Do not include supervised days previously adjusted on Line 11; also, do not include reserve bed days previously adjusted on Line 13.).....		
17. Program Resident Days (To Summary Schedule, Sec. III, Line 7)	6447	

FACILITY 2018 COST REPORT



## Appendix G: Medicaid Cost Report

Medicaid Nursing Home Rate Methodology Review  
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SCHEDULE O-1  
CENSUS DATA

PART I			PRIVATE					MEDICAID				MEDI- CARE		OTHER (SPECIFY)					TOTAL
			1 In House	2 Hosp	3 (Ex- cess)	4 Leave	5 Other	6 In House	7 Hosp	8 (Ex- cess)	9 Leave	10 In House	11 Hosp	12 (Ex- cess)	13 Leave	14 Other	15		
	Month	Year																	
1.	Jan	2018	186					363	1			11					561		
2.	Feb	2018	165	1				300	8	3		11					474		
3.	Mar	2018	165					336	5			11					517		
4.	Apr	2018	160					330				30					520		
5.	May	2018	164					360	6	1		31					561		
6.	Jun	2018	153	3				422				8					586		
7.	Jul	2018	139	10	5			416	5			6					576		
8.	Aug	2018	153					431	3			25					612		
9.	Sep	2018	125					388	4			30					547		
10.	Oct	2018	124					402									526		
11.	Nov	2018	90					390									480		
12.	Dec	2018	93					403									496		
	Total		1717	14	5	0	0	4541	32	4	0	152	0	0	0	0	6456		

PART II ASSISTED LIVING CARE

14.	Jan	2018	31					124									155
15.	Feb	2018	28					112									140
16.	Mar	2018	62					93									155
17.	Apr	2018	62	4				182									248
18.	May	2018	93					376	2								471
19.	Jun	2018	90					358									448
20.	Jul	2018	93					372									465
21.	Aug	2018	93					367	5								465
22.	Sep	2018	90					360									450
23.	Oct	2018	93					372									465
24.	Nov	2018	90					360									450
25.	Dec	2018	93					350	10	5	0	0	0	0	0	0	453
26.	Total		918	4	0	0	0	3426	17	5	0	0	0	0	0	0	4365

PART III GRAND TOTALS

27.	Grand Total		2635	18	5	0	0	7967	49	9	0	152	0	0	0	0	10821
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FACILITY 2018 COST REPORT